A Review of Congregate Housing in the United States

New York State Office For The Aging

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This report provides background information on the status of the congregate housing/services concept for older adults in the United States, including a comparison of five state-sponsored congregate services programs.

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Executive Summary

Theoretically, any shared living arrangement among a group of unrelated persons of any age operating as an economic unit is a congregate housing arrangement. Currently, however, the term "congregate housing" is used by policy makers to specify a multi-unit or shared housing environment for the elderly which integrates private apartment living with supportive services. The term connotes a philosophy purporting that appropriate shelter is only one of a number of services required by older adults (those aged 60 and over) to maintain themselves as independently as possible in their later years; that, in designing appropriate living alternatives for older adults, housing and supportive services should be considered as one rather than as two disparate categories of needs. Usually, these supportive services are congregate meals, housekeeping, transportation, 24-hour emergency response, and personal care (assistance with ADLs* and IADLs*).

The following report was developed to provide policy analysts and program planners with a description and understanding of congregate housing in the United States. The name "congregate housing" is used indiscriminately by developers of many housing/services models, and congregate programs are called by a variety of names. Therefore, this report will use the term "congregate housing/services concept" to include any non-institutionalized, multi-unit housing project for the elderly that includes private residential space and the provision or availability of an optional services component that has been developed or coordinated specifically for the residents of that housing project.

While the concept of congregate living is over 2,000 years old, governmental involvement in promoting the concept as a means to contain the costs of institutional care is only about 20 years old. Through the Department of Housing and Urban Development, the federal government legislatively promoted the construction of congregate housing in 1970 and supplemented that effort with the Congregate Housing Services Program in 1978 (currently operating in approximately 62 sites across the country). Through a 1979 Memorandum of Understanding between the federal Administration On Aging and the federal Farmers Home Administration, a demonstration Congregate Housing program was implemented in ten sites across the country, with the Farmers Home Administration supporting construction loans and the Administration On Aging providing funds for supporting the services component. The majority of state-sponsored demonstration congregate programs were implemented between 1976 and 1981. While the fledgling state-sponsored congregate effort has expanded steadily, the private congregate housing industry has flourished across the country in response to a rapidly growing market demand for this housing alternative.

Four situations merged to persuade state governments to develop congregate programs, as well as other community-based service programs, to meet the needs of a growing older adult population:

1. Specialized housing projects built in the 1960's and 1970's for low income, "well elderly" found that their resident populations did not turn over but, rather, aged-in-place. Managers found it was difficult to force out an aged resident who needed only assistance in some daily activities in order to remain in the housing project.

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* ADL (Activities of Daily Living): bathing, toileting, grooming, dressing, transferring, mobility, eating.

* IADL (Instrumental Activities of Daily Living): preparing meals, shopping, doing laundry, housekeeping, using the telephone, handling personal business, self-administering medications.

2. The ballooning costs of Medicaid for institutional long term care and the projected growth of the frail elderly population (those who are 85 and over) needing this care pushed policy makers to promote community-based and in-home care as a cost containment strategy.

3. The growing number of older adults and an increase in life expectancy focused research and political attention on the needs and preferences of older adults.

4. Services required by the growing number of older adults were inconsistently available, uncoordinated, often inaccessible, often unaffordable.

States have sponsored a variety of models of congregate housing/services programs, reflecting the growing acknowledgement that alternatives within a continuum of services, rather than several categorized care levels, are needed to appropriately meet the diverse needs of older adults. These models range from the minimum of assigning one case manager/broker to a "well elderly" senior housing project in order to facilitate residents' accessing available community services, to a housing facility specifically constructed for functionally impaired older adults to receive recreational, social, personal care, and nursing/medical services.

This report is an overview of the congregate housing/services industry in the United States, including several elements of the housing preferences of older adults, cost comparisons of institutional vs. housing/services environments, the advantages and disadvantages of combining housing and services, and a comparison of five states that have implemented one specific congregate housing/services model (Vermont, Maine, New Jersey, Maryland, and New York). The following were utilized to complete this report:

1. A review of the literature.

2. Discussions with officials of 18 state units on aging.

3. Site visits and discussions with the managers of a variety of private and public congregate housing/services programs and facilities.

The findings from several comprehensive studies were used as background information for this report:

1. An evaluation of the federal Department of Housing and Urban Development's Congregate Housing Services Program, by Sylvia Sherwood, et al, 1985.

2. A nationwide survey of public and private congregate programs by I. Malozemoff, J. Anderson and L. Rosenbaum for Urban Systems Research and Engineering, Inc., 1978. A stratified sample of 27 facilities representing three service levels, three rent levels, and four geographic regions of the United States was drawn from five major listings of housing for older adults.

3. A survey of residential care programs representational of the different types implemented in states east of the Mississippi River, by V. Mor, S. Sherwood, and C. Gutkin for the Hebrew Rehabilitation Center for the Aged, 1986. A combination of purposive and random sampling procedures were used to draw a sample of 230 state-supported residential programs in five eastern states.

Based upon this overview of the industry, several conclusions became apparent:

1. Per diem costs of care in a skilled nursing facility are substantially greater than per diem costs of care in a congregate housing/services facility. States justify the development of congregate programs on the basis of this per diem cost differential. On an individual case basis, net cost savings can be realized if a person who is inappropriately placed in a skilled nursing

facility is transferred from that facility to a congregate program, or if a person who is about to enter a nursing home is diverted to a congregate program.

2. The Diagnostic Related Groupings prospective reimbursement system for hospital acute care is resulting in longer and more intensive at-home recuperation periods requiring informal support beyond a level which families can reasonably manage. Also, in New York, the Resource Utilization Groupings reimbursement methodology for skilled nursing facilities provides a financial incentive for these facilities to accept the most ill patients (in order to achieve a higher reimbursement rate) in place of those requiring a lesser level of care who were previously preferred by nursing home operators. These two policy changes in public reimbursement systems have created a client shift in the continuum of services, leaving several categories of older adults with temporary impairment or low level chronic impairment with an insufficient supply of appropriate services.

3. Demographics indicate that the portion of the population aged 85+ termed the "frail elderly" will increase 40 per cent in the next 10 years and will require precisely that level of services provided by congregate housing/services programs. This increase in the frail elderly will coincide with a reduction in the younger age groups traditionally available to provide informal care for this group. It is estimated that up to three million elderly are currently funtionally eligible for congregate services.

4. The major differences between public and private congregate housing/services programs are the income level and functional impairment of the targeted populations and the range of services provided by operators. Private proprietary programs target private-pay clientele and typically provide congregate meals, housekeeping, 24-hour emergency response, and scheduled transportation. Private, non-profit programs target private-pay clients, but may partially subsidize a limited number of participants. Operators of these programs provide the same services as proprietary programs, but have begun modifying their services to include personal care and social services to accommodate the increasing frailty of their populations who are aging-in. Publicly supported programs target low income, frail clients. Personal care, social services, and, often, case management are an integral component of publicly supported programs, in addition to congregate meals, housekeeping, scheduled transportation, and 24-hour emergency response. Publicly supported programs are broadening their target groups to include higher income levels as a means of cross subsidization and in recognition of the service needs of all older adults.

5. Of the 18 states contacted for this report, five have implemented a program of subsidized services for a specified percentage of residents in existing senior housing projects. The major differences between these five congregate services programs are the reimbursement methodology and the program intent. Vermont, Maine, New Jersey, and Maryland tie their service subsidy funds to the program through a direct reimbursement to program operators from state general funds or specialized state funding streams, while New York ties service subsidy funds to the program participant via a state supplement to the resident's federal SSI payment. Vermont, Maine, New Jersey, and Maryland view their programs as a second line of defense; that is, as a mechanism for filling gaps and insufficiencies in the existing community service network, while New York views its program as a first line of defense; that is, as a separate program on the continuum-of-care, providing a coordinated total core set of services.

6. The advantages of congregate housing/services programs were found to be: the residential environment imitating life in the general community; the flexibility in meeting individualized needs; the promotion of aging-in- place and the reduction of relocation trauma; the increase in resident activity and morale; and the inherent financial incentive for operators

to provide minimum therapeutic intervention, which promotes residents' maintaining a sense of independence and decreases the potential for residents assuming a "patient mode." A potential disadvantage of congregate facilities that admit as residents only frail elderly who require a specified level of care is the creation of another segregated "institutionalized" living environment. Also, injecting a formal services program into a senior housing project for availability to only a limited number of participants often stigmatizes those participants as sick and generates fear among the remaining residents of turning their residential facility into a nursing home.

7. Evaluations of congregate housing/services programs by sponsors and independent researchers conclude that there is not one best concept model nor one best way to deliver the program's services.

8. Flexibility in service delivery to promote choice for participants is preferable. A formula for an "ideal" congregate housing/services program is difficult to achieve, and not necessarily desirable.

Sample Models of the Congregate Housing/Services Concept

• **Senior Resident Advisor Program** (operated by the New York City Public Housing Authority in 16 of its apartment buildings): A paraprofessional who lives in the building is available during the day to all residents of the building for counseling, information and referral, social activities, and brokering of community services. This person is also available 24 hours a day for emergency intervention.

• **Congregate Housing** (traditional model operated by private non-profit and proprietary sponsors throughout the country, for "well-elderly"): Apartments or cottages; residents pay a monthly fee which includes rent, utilities, 1 to 3 congregate meals, housekeeping/chore services, 24-hour emergency response, and essential transportation. Personal care services are individually contracted between residents and private vendors.

• **"Medical Model" Congregate Services Program** (private non-profit services programs operating throughout the country in "well-elderly" senior apartment buildings in which a significant number of residents have aged-in-place and are experiencing chronic impairments; usually operated in conjunction with the program sponsor's medical facility—nursing home or hospital): Residents pay a monthly fee which incudes the rent, utilities and traditional congregate facility services, but also includes operator-facilitated access to personal care services and facilitated access to the medical facility's staff and services.

• **Congregate Housing Facility** (often state-subsidized): Entry is limited to residents who are assessed as requiring congregate meals and supportive services. This program is similar to New York's Adult Homes except that each resident has his own private apartment, including a kitchen, and the facility does not always require licensure; abbreviated staff may remain on site during night hours.

• **Free Standing Shared-Living Residences, or Shared Apartments** (operating in many states): A small number (3-8) of unrelated individuals live together in a single family home or in an expanded apartment in a multi-unit apartment building and participate, as needed, in a program of supportive services which can include any of the following: congregate meals, housekeeping/chore service, social services, information and referral, transportation, personal care, case management, shopping aid, help with personal business matters and aid in managing self-medication. Operators and sponsors can be site-specific or can oversee several programs, sharing staff and equipment among programs in several locations.

• **Congregate Services Program** (state subsidized program of supportive services for a capped percentage of the residents in senior housing buildings): A specified number of an apartment building's residents receive any of a core set of services, including the traditional congregate services plus social services and personal care services. The program can be funded through a variety of means such as a state's general funds, a state's specialized funding stream such as lottery or casino revenues, a state's other in-home services program, a state's supplement to federal SSI grants. Program participants may be dispersed throughout the building or may be assigned to apartments on one designated floor or wing of the building.

Background

Persons aged 60 and over represent 16 per cent of the nation's population, and that figure is expected to grow to 26 per cent by 2025 (New York State Office For Aging, 1984). The fastest growing segment of this group is that portion typically referred to as the frail elderly, those who are 85 and over.

Medical advances and changes in life styles have resulted in a continuing increase in life expectancy. However, that period in the later years characterized by chronic impairment has also lengthened. The proportion of older adults who will require some measure of assistance in daily living, and the aggregate cost of this care, will increase dramatically.

During the 1970's and 1980's, in response to the impending growth in the number of frail elderly and the potential for great expenditure of public dollars, states implemented a variety of community-based service programs to replace costly institutional care for impaired older adults. This trend away from institutionalization is supported by gerontologists' findings that older persons negotiate the aging process more successfully if allowed to live as independently as possible, amid familiar surroundings, and with available choices in living environments.

Four situations came together to persuade states to develop community-based alternatives:

1. Specialized housing projects built in the 1960's and 1970's for low income, "well elderly" found that their resident populations did not turn over, but rather aged-in-place. Managers found it was difficult to force out an aged resident who needed only assistance in some daily activities in order to remain in an independent living environment.

2. The ballooning costs of Medicaid for long term care and the projected growth of the frail elderly population (85+) needing this care pushed policy makers to promote community-based and in-home care as a cost containment strategy.

3. The growing number of elderly and an increase in life expectancy focused research and political attention on the needs and preferences of older adults. Research showed that if their environment is a viable one, older persons prefer to age in place (Ward, 1985; Sherman, 1985; Lawton, 1978); and that involuntary relocation and over-intensive service intervention have detrimental physical and emotional effects on the elderly (Lieberman and Tobin, 1983).

4. Services required by the growing number of older adults are inconsistently available, uncoordinated, often inaccessible, often unaffordable.

One alternative community-based program developing across the country is termed the congregate housing/services concept — the integration of supportive services within a multi-unit residential housing facility. This concept advances the philosophy that housing is only one of a number of services required by older adults to maintain themselves as independently as possible in their later years, and that appropriate housing and necessary support services should be planned and delivered together when designing viable living environments for older persons. Traditionally, the support services included are congregate meals, housekeeping, linen service, scheduled transportation, 24-hour emergency response, and, in recent years, personal care (assistance with ADLs* and IADLs*). This provision of housing and

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services together provides a flexible, semi-independent residential environment for elderly persons to bridge the gap between the extremes of complete self-sufficiency and the custodial care of an institution.

In the United States, the congregate housing/services concept has its roots in the boarding house of earlier years where residents came together in a common dining room for the main meal of the day. They shared a common living room and often looked to each other and the boarding house owner for mutual assistance. However, the concept of sharing shelter, meals, and support is over 2,000 years old. What is new is governmental involvement over the past 20 years in promoting the development of the concept. Out of 18 states contacted for this report, 12 states defined their services-to-the-elderly programs as "congregate programs." Eight of these programs were initiated between 1976 and 1981. Through the Department of Housing and Urban Development, the federal government legislatively promoted the construction of congregate housing in 1970 and supplemented that effort with HUD's Congregate Housing Services Program in 1978 as a demonstration project (currently the program is operting in 62 sites in public housing and Section 202 facilities). Through a 1979 Memorandum of Understanding between the federal Administration on Aging and the federal Farmers Home Administration, a demonstration Congregate Housing program was implemented in ten sites across the country, with the Farmers Home Administration supporting construction loans and the Administration on Aging providing funds for supporting the services component. This program has not expanded significantly because supportive subsidies for the services component are no longer available.

While the fledgling publicly supported congregate housing/services endeavor is growing across the country, a well developed private congregate housing industry has developed and is expanding in response to a ready market for this housing alternative. Proprietary private congregate projects generally target higher income, well elderly who appreciate the safe environment and social opportunities and who often view the services as a convenience rather than a requirement. Traditionally, services in these facilities are congregate meals, housekeeping, scheduled transportation, and 24-hour emergency response. Residents have the option to contract privately for in-home health care when needed, but operators are adamant about residents leaving the project as soon as impairment compromises their independence.

Private, non-profit congregate projects target moderate income older adults, but many will subsidize a limited number of residents, using sponsor- or resident-endowed funds. Many non-profit congregate housing sponsors developed their services programs for frail residents in their "well-elderly senior housing" in response to the same aging-in phenomenon that is occurring in all senior housing across the country. A trend is seen among these sponsors to increase the number and intensity of available services to maintain their residents in independent living units and avoid relocation to institutions. These sponsors have added social services and a personal care component to their service package, and projects affiliated with hospitals and nursing homes make use of these institutions' professional staffs for congregate residents' medical and nursing needs.

Publicly sponsored programs target low income, frail elderly who are at risk of institutionalization. In addition to providing congregate meals, scheduled transportation, housekeeping, and 24-hour emergency response, social services, personal care, and, often, case management are an integral part of the service package.

Congregate housing/services programs state as their initial, formal intent, the provision of care up to but not including

nursing beyond intermittant, short-term nursing care. This implies adherence to the traditional congregate housing philosophical intent to provide aid to persons who will remain independent if given some assistance with Activities of Daily Living, with those requiring a higher level of care moving from the congregate environment to an institutional level. In actuality, more and more residents are purchasing their own extensive in-home homemaking and nursing services, and many congregate facilities are treading a fine line between providing non-health and health-related services. It is not rare to find bed-fast individuals requiring 24-hour supervision and complete meal service.

The level of care required in congregate housing/services programs is gradually intensifying because of the increased longevity of residents, the public policy emphasis on delaying or avoiding institutionalization, the availability of in-home care providing service choices for individuals, and the cost of nursing home care inhibiting families from choosing nursing homes as a care alternative for their elderly family members.

Also, governmental policies and changes in health care reimbursement methodologies are resulting in an insufficient number of appropriate services for those who do not qualify for the intensive care of a skilled nursing facility, but who require more help than can be managed by families or the older persons themselves. For example, Florida consolidated its ICF/SNF rate into one reimbursement for SNF care and is finding that persons such as Alzheimer's and acting-out patients need more care than Florida's Adult Care Living Facilities can manage through their personal care level of services, but are too expensive to institutionalize at SNF rates. Florida is now considering a demonstration project of congregate homes for special groups which would be funded out of general funds because there is no medical reimbursement for these clients.

Two regulatory changes cause concern that the result will be the same in New York. The institution of the Resource Utilization Groupings method of nursing home reimbursement is motivating the operators of the restricted number of nursing homes to select only patients requiring very intensive levels of care in order to qualify for the highest reimbursement rates, leaving the previously preferred patients requiring less intensive care to choose other alternatives. Also, nationwide institution of the prospective payment system for hospital acute care (Diagnostic Related Groupings) has increased the at-home recuperation time of hospital patients, requiring a higher level of care than families and patients are prepared to handle.

Thus, greater life expectancy, lengthening periods of frailty, reluctance to relocate, in-home care alternatives, and policy/reimbursement changes are putting pressure on the congregate housing/services industry to serve a larger and increasingly impaired population.

Survey of States

- State governments have instituted varying programmatic responses to service needs of older persons, and these responses directly reflect differing policy-level attitudes about the elderly.
- Congregate housing/services projects have developed in response to consumer need and have developed haphazardly across the United States in the absence of a macro-level elderly housing policy.
- Research/evaluations have shown there is not a generalizable "best way" to implement a congregate housing/services project. A major advantage of the concept is the variability inherent in designing viable models.
- State-supported congregate programs are funded through general funds, specialized funding streams such as casino revenues or state lotteries, SSI supplements, and additions to existing state-wide social services program funding streams.
- Vermont, Maine, Maryland, and New Jersey offer congregate services programs similar to New York's Enriched Housing Program. New York's program differs in reimbursement methodology and in program intent from the programs of the other four states.

The development of community-based services, including congregate housing/ services programs, has not progressed in a consistent manner across the country. State governments have instituted varying programmatic responses to the service needs of older persons, and these responses reflect differing policy-level attitudes about the elderly:

Some states have only a few elderly, have not felt the political pressure to respond to that constituency, and have little or no elderly housing/services programs.

Some state policy makers address the issue of age segregation. For example, Wisconsin does not wish to separate (ghettoize) its older adults from the rest of the community and wishes to discourage the growth of large care facilities which connote institutional living. Wisconsin has initiated a $16M Community Options Program for all ages of medicaid-eligible persons who are at risk of institutional placement, and provides whatever services are needed to keep these persons in their own homes or in facilities housing one to nine persons. On the other hand, Connecticut's congregate housing program segregates frail elderly through the construction or rehabilitation of facilities specifically designed as congregate facilities for residents whose functional level requires assistance.

Other states are attempting to increase service options to all older adults rather than focusing on a particular sub-category such as "frail" or "low-income." Maryland is an example. In an attempt to make the existing large private pay congregate housing industry available to low/moderate income elderly, the state of Maryland has instituted a capped subsidy to augment a sliding scale to provide shelter and services in family homes certified to care for 4 - 15 persons. Maryland also has a congregate services program in existing subsidized senior housing; and, in response to requests from the managers of unsubsidized senior housing developments, the Maryland Office On Aging will provide technical assistance and certification to implement their services program on a private pay basis for those older adults who do not qualify for subsidies but who cannot afford Life Care Communities.

Ohio uses its monies to promote the development of congregate housing/services projects for well elderly with an incentive grant for construction. The Department of

Aging controls rents, but does not subsidize services. Ohio also has an Adult Home program for those who need the personal care level of services.

The state of Massachusetts provides for congregate shelter and services through shared apartments and family homes, but all congregate housing residents receive any needed services through the state-wide $109M home care program serving 46,750 clients in the general community. Massachusetts plans to change its income guidelines to allow higher income older adults to participate in the congregate shelter/services program.

Most states offering a program they define as congregate housing have a number of additional programs in place to offer alternatives to older adults who are less than self-sufficient. One example is Pennsylvania which has Personal Care Boarding Homes, a Shared Housing Program, a Domiciliary Care Program, Department of Housing and Urban Development congregate services projects, an in-home service management system, as well as an extensive state-regulated Continuing Care Retirement Community industry.

In addition to government-sponsored congregate housing/services projects, all states have seen the development of a diverse private congregate housing industry, with rate structures and services reflecting the targeted income group. Sponsorship varies widely, including non-profit organizations, individuals, religious groups, hospitals, nursing homes, public housing authorities, area agencies on aging, proprietary developers, corporations, and health care chains.

Definition of Congregate Housing

Theoretically, any shared living arrangement among a group of unrelated persons of any age operating as an economic unit is a congregate housing arrangement. Currently, however, the term "congregate housing" is used by public policy makers to specify a housing environment for older adults (aged 60+) which integrates private apartment living with supportive services. The lowest common denominator shared by housing projects designated as congregate facilities is a private living unit together with the availability of a congregate meal program operating in a central dining room (Urban Systems, 1976).

A major advantage of the congregate housing/services concept is the variability inherent in designing models of the concept. While this allows for flexibly addressing needs and preferences of targeted resident populations, it makes definition and description of the concept difficult and cost comparisons between states and programs inconclusive. Several examples will illustrate this difficulty in specificity and comparability:

1. Sherwood, et al, (1986) surveyed 118 congregate programs nationwide that were identified by 21 different names, included different population profiles, and encompassed a range of services.

2. Congregate housing is defined in the 1970 United States Housing Act as "low rent housing in which some or all of the dwelling units do not have kitchen facilities, and connected with which there is a central dining facility to provide...meals for elderly families under terms and conditions to permit a self supporting operation."

3. Powell Lawton (1976) states that the term congregate housing has no satisfactorily accurate definition. For his study of the impact of congregate and traditional housing on elderly tenants, he defines congregate as housing that offers a minimum service package that includes some on-site meals served in a common dining room, plus one or more of such services as on-site medical/nursing service, personal care, or housekeeping.

4. The state of Connecticut defines congregate housing as "a form of residential environment, consisting of independent living assisted by congregate meals, housekeeping and personal service for persons 62 or older, who have temporary or periodic difficulties with one or more essential activities of daily living, such as feeding, bathing, grooming, dressing, or transferring" (Congregate Housing Study Committee, 1985).

5. The state of Vermont defines congregate housing as a combination of shelter, nutrition, housekeeping, and personal and social services provided in part through government assistance to elderly residents in a facility containing independent apartments and a common dining room (Guidelines, 1977).

6. For the state of Massachusetts, a congregate house can have as few as four residents or more than 50; the setting can be one large, shared apartment or a shared one-family home, or small apartments in a larger conventional building. "Living in a congregate house means coping with a set of unique issues and problems on a daily basis. These include residents' psychological expectations, their diverse support networks, sharing, incapacity, and leaving. Residents in congregate housing must be seen in terms of their physical shelter needs, service requirements, and social abilities, and all of these as they change over time" (Massachusetts Department of Elder Affairs, 1984).

7. According to Mor, *et al*, (1986), the Federal Register classifies any home which routinely provides more than room and board to the public as a residential care home (alternately known as domiciliary care, *congregate care*, or adult foster care). Palmer estimated that there were 600,000 residents in residential care facilities in 1983 across the United States (Mor, 1986), with the types of homes and their names differing from state to state and within states as a function of the type of population served. Mor estimated that elderly residents constitute between 40 and 60 per cent of these residential care facilities.

Mor, Sherwood and Gutkin's (1986) nationwide survey of residential care programs used the definition "a set of living arrangements operated by someone unrelated to the residents, which provide room, board, and personal care or supervision..." However, the residential care homes identified by Mor, while "also known as congregate care," are generally state-licensed and regulated Residential Care Facilities (alternately known as adult homes and assisted living facilities). These facilities should be differentiated from what is generally considered to be congregate housing or what is meant by the congregate housing/services concept in this report. The two can be confused because the range of services provided and the characteristics of the resident populations in both are often the same. However, state regulated and licensed Residential Care Facilities are constructed specifically to house individuals assessed as requiring services prior to admittance to the facility. RCFs predominately provide private bedrooms rather than private, complete apartments for residents. They mandate the provision of three congregate meals per day, provide a routine core set of services to all residents, and are more "institutionally" defined in terms of beds rather than in terms of independent living units.

Residential Care Facilities can be viewed as a level of care rather than as a housing option. In contrast, facilities which fall within the congregate housing/services concept developed from a social model perspective. They provide the same range of services as RCFs, but these services are elective and made available as an in-home services program to residents in their private apartments. They do not require licensure or state regulation; and while many facilitate the provision of personal care services, these

services are contracted individually by the resident and a private home health agency.

Definitional lines begin to blur when states institute subsidized congregate housing/services programs in senior housing buildings and require regulation and monitoring by a designated state agency. An example is New York State's Enriched Housing Program which is a state-supported services program (including a congregate meal, social services, and program-sponsored personal care) for a capped number of residents in well-elderly senior housing buildings. While program participants are dispersed throughout the building, reside in their own private apartments, and utilize only those services they are assessed as needing, all participants are charged a standard fee for a set package of services, the program is certified and licensed as a New York State Adult Residential Care Facility, and the monitoring agency (New York State Department of Social Services) does not consider the program a congregate housing/ services program. In contrast, Maine, Vermont, Maryland, and New Jersey have state-supported programs similar to New York's Enriched Housing Program and do define theirs as congregate programs.

8. As the frail elderly population has grown in number, health care industry developers (nursing homes, hospitals, health maintenance organizations) have begun focusing on this population as an avenue for diversification. These developers draw a definitional distinction between "congregate housing" and "assisted living," with congregate housing being defined as "one step up from independent living" and assisted living defined as "one step down from a skilled nursing facility." The implication is that assisted living requires the provision of a higher level of services than does congregate housing. However, residents of existing congregate facilities around the country often require the same intensity of service care as those targeted for assisted living facilities. The actual difference between the two options appears to be the same as between congregate housing/ services projects and residential care facilities. Very often, personal care services are provided by an assisted living sponsor as part of the monthly fee, making these facilities subject to the same licensure as residential care facilities.

9. As the concept of integrating housing and services has grown in acceptance, modified versions continue to be created. For example, a Continuing Care Retirement Community is a specialized housing and supportive services environment with a medical component (skilled nursing facility). It is a congregate campus community accessible to higher income elderly which incorporates contractual lifetime tenancy and care. A Brandeis University/Philadelphia Friends Services for the Aging joint project will develop a non-campus CCRC model for moderate/lower income older adults who will continue to remain in their own homes in the general community, but a finite group will share medical and social services. A Senior Resident Advisor Program in New York City's Public Housing Authority senior housing projects does not include congregate meals but does provide on-site staff to provide counseling, coordination/brokering of community services, and 24-hour crisis intervention for residents. In Pennsylvania, Lehigh County is involved in assisting the development of congregate housing under a "cooperative" arrangement, with residents buying "shares" in the housing component and services provided by several religious-affiliated sponsors working together as a non-profit umbrella coordinating organization.

Across the country, congregate housing/ services programs have developed in response to consumer demand and have developed haphazardly in the absence of a macro-level elderly housing policy. Program sponsors and operators have had no prototype to copy, but have created their own models to address the particular needs of

their specific populations. Thus, the congregate housing/services concept has many faces. However, the basic programmatic parameters and the fundamental intent are always the same: (1) it is the integration of a private living environment and elective supportive services; (2) it is intended to enhance and maintain private, independent living and delay or avoid institutionalization.

States, through research, pilot projects, and permanent programming, have not determined a generalizable "best way" to deliver the programs; thus, no state has instituted a formulated model throughout its state. The same services are delivered in a myriad of ways and at variations in cost dependent upon such variables as:

- Whether a service is locally available through another funding stream.
- Whether a service can be contracted through a nearby provider, or must be provided by site staff (urban vs. rural/suburban issue).
- The extent of community involvement in the program (volunteer staff, paraprofessionals, local monetary and in-kind contributions).
- A resident population's functional profile (paraprofessional vs. professional staff).
- The number of a program's participants (circuit rider coordinator, shared staff, part-time/full-time staff).
- The political environment in each locale, dictating which organizations serve which populations.
- The extent of cooperation among local agencies to pool resources (for example, transportation).
- Whether the locale is services rich or poor (competitive prices and quality of services available; unique local services; contracted vs. onsite staff).

Comparison of State-Sponsored Programs in New York, Vermont, Maine, New Jersey, Maryland

This "Review of Congregate Housing in the United States" is meant primarily as an educational tool for program and policy analysts in New York for use in shaping the future development of the congregate housing/services concept in New York. Thus, this section of the report will compare New York's current state-sponsored congregate housing/services program with the state-sponsored programs of four states, of the 18 surveyed, whose programs are structurally similar to New York's.

States set congregate housing/services subsidy eligibility requirements based on income and functional level. One of the easiest ways to target a state's low-income, frail population is to focus the congregate housing/services program on frail elderly in independent senior housing projects. A number of states have done this, including Vermont, Maine, New Jersey, Maryland, and New York.

All five of these states dictate that program participants require help because of ADL impairment, but not need continuous nursing.

All five offer the same core group of services: varying numbers of congregate meals, housekeeping, homemaking/chore, scheduled transportation, 24-hour emergency response, social services, personal care, and brokering for needed services not directly provided by program staff.

Four of the programs are administered by the states' Offices on Aging; New York's program is called Enriched Housing and is administered by the State Department of Social Services.

The aggregate amount of money each of the five states spends varies, as does the average monthly state subsidy per person for the program:

State	Annual State Expend.	Total No. Partic.	Avg. Mon. Subsidy Per Person	Source of Funds
Vermont	$47,000 ($106,800 appropri.)	89	$ 44 ($100 Cap)	Gen. Funds
Maine	$300,000	169	150 ($150 Cap)	Gen. Funds
New Jersey	$800,000	590	113 (No Cap)	Casino Rev.
Maryland	1.1M	902	100 ($100 Cap)	Gen. Funds
New York	1.2M	382	250 ($365/395 Cap)	SSI II

There is wide variance in the five states' average subsidy per person per month. A critical factor which explains the variance between New York's and the other four states' average service subsidy is each program's designated purpose within the existing services network. Vermont, Maine, New Jersey, and Maryland mandate that existing federal, state, and local programs and funding streams be used first, with the congregate services program used to supplement insufficient services or gaps in services. Therefore, Medicaid, Titles III-B and C of the Older Americans Act, local transportation entitlement programs, Title XX of the Social Security Act, food stamps, USDA surplus food and other welfare programs, etc., are utilized before congregate program funds.

The reverse is true in New York, with the congregate services program (Enriched Housing) being the first line of defense for program participants before other funding streams are utilized. For example, in New York the Enriched Housing Program is mandated to provide one congregate meal per day utilizing program staff and funds even if other congregate meal programs are easily accessible. If an Enriched Housing resident is assessed as needing one congregate meal per day and she participates

in an Older Americans Act Title III-C congregate meal site program, that III-C meal will be considered the resident's second congregate meal of the day and she must still participate in the Enriched Housing Program's congregate meal. The III-C meal funded with federal dollars is not used in place of the Enriched Housing Program's meal. Also, an Enriched Housing participant's first six hours of weekly homemaker/personal care services must be provided via the Enriched Housing Program's staff and funds. Homemaker/personal care needs which go beyond the initial six hours can then be met with other funding sources such as Medicaid.

The intent in New York reflects a desire to provide a total, coordinated, cohesive program as a means of addressing fragmentation, inaccessibility, and inconsistency in the community service system. Each discrete building's Enriched Housing program of services is developed for and delivered to only the residents of that housing facility. The intent in the other four states is to use the program to provide a formal mechanism for locating and filling gaps and insufficiencies in the existing community service system. Access to services which are available to the wider community is facilitated and coordinated for delivery to congregate program participants by the congregate program's coordinator.

Other elements contribute to the five states' average subsidy variance:

1. Program mandates: Vermont's program ($44 average subsidy) does not *mandate* the provision of congregate meals, and any weekday congregate meals required by participants are provided through the Older Americans Act Title III-C program. Thus, the $44 figure does not include meal service. Maryland (average: $100) mandates three congregate meals a day and utilizes III-C to the extent possible. New York (average: $250) mandates one congregate meal a day to be provided with Enriched Housing Program funds.

2. Participants' contribution to program costs: Although all five programs target low income elderly, no state dictates a ratio of private pay to subsidized participants. All five states allow private pay eligibility for participants above designated income limits, and all utilize a sliding scale formula to determine participants' contributions. The aggregate average income of a program's subsidized participants will affect the average subsidy per program participant. For example, only 22 per cent of Maryland's ($100) participants are SSI eligible, whereas 75 per cent of New York's ($250) are SSI eligible. However, it should be noted, in comparing New York's Enriched Housing Program's average services costs per month to other states' average congregate services costs, that the average cost to New York for this specific program is not $250 but is, in reality, $178. The program's subsidies are funded out of the state's Supplemental Security Income Program at the "Congregate Living Level II" for Adult Residential Care Facilities. If an Enriched Housing participant drops out of the Enriched Housing Program, he would no longer be eligible for the Level II (Congregate Living) subsidy, but would continue to be eligible for the state SSI subsidy at Level I ($71.91), the state's "Individual Living Alone" grant ($250 - $71.91 = $178.09).

3. Cost-sharing formula: New Jersey ($113) has the median average monthly subsidy. New Jersey determines its subsidy by a formula which involves a percentage of the service plan cost for each individual relative to his discretionary income together with the cost for each service in that individual's project area. Subsidies are limited to those whose *discretionary* income is less than 126 per cent of the OMB poverty level, and every participant must pay at least five per cent of his service costs. Average monthly participant contribution is $76. Maine ($150) does not have a uniform statewide methodology for determining participant contribution, but each program

operator has discretion to develop his own cost- sharing formula. Vermont's ($44) method of computing participant contribution is uniform statewide, and subsidies are limited to those whose incomes are below 80 per cent of the median income in their counties.

Maryland ($100) specifies no income eligibility criteria, but the program is located in publicly assisted housing. Participant cost-sharing is determined as a portion of gross income minus 10 per cent, personal allowance, rent, food and medical expenses. However, Maryland's tenant selection process for any one project factors in applicants' income ranges, age ranges, and functional levels to arrive at a case mix such that the average state subsidy of $100 per person is not exceeded at any one project. New York's subsidy ($250 average) is available to participants who are SSI eligible. New York has developed a legislatively set "standard of monthly need" which includes room, board, and supportive services. In 1987, this "need" cost figure was $705/735 (upstate/downstate). A participant eligible for the program's subsidy qualified for the state's SSI Congregate Living Level II supplemental funds in an amount which, when added to his own countable income and his federal SSI grant ($340), equaled $705/735.

4. Program components eligible for reimbursement with state funds: Maine ($150) will reimburse for a portion of administrative, housing director, and transportation expenses; a part-time care manager (AAA staff); on-site food service staff and food supplies if III-C cannot be accessed; home health agency sub-contracts or, if too expensive, homemaker staff costs. Maryland ($100) will reimburse for food service costs if III- C cannot be accessed, a program coordinator, direct homemaker staff or home health agency sub-contract, counseling, some transportation.

New Jersey ($113) will reimburse for a coordinator, home health agency sub-contract or part time homemaker aides, food service costs if III-C cannot be accessed, transportation for food service, other costs related to food. Vermont ($44) pays for a part-time coordinator, weekend meals and special diet meals, home health agency sub-contract or part time homemaker aides, some transportation, a portion of the AAA director and bookkeeper, and lifeline. New York ($250) pays for food service staff and supplies, home health agency sub-contract or part-time homemaker aides, scheduled transportation, program coordinator.

5. In addition to services listed as core program components, operators in the five states provide discrete ancillary, non-medical services assessed as required by a participant to have his needs met in order to maintain independence. These are normally reported in the budget under "other," and can vary widely from project to project. Projects' use of volunteers also varies, and these in-kind costs are not included in determining average program costs. None of the five states' program subsidies includes costs of shelter, and only New York provides a one-time separate start-up grant for program planning and development.

6. A possible reason why Maine subsidizes at a 50 per cent higher figure than Maryland and Vermont may be the differences in these programs' initiation dates. States will attempt to arrive at a subsidy figure through a state-wide survey of service-unit costs or through the results of a demonstration project. Both Maryland's ($100) and Vermont's ($100) programs were begun in the late 1970's whereas Maine's ($150) started in 1984 when labor, food, and other costs were higher. Maryland's new (1986) family home congregate services program will be subsidized at $200 per person per month based on a very recent survey of costs across the state. In New York, subsidy amounts are legislatively set and revised in response to a periodic determination of "a standard of monthly need" dependent upon the type of living

arrangement (living alone, with others, with a family, in a residential care facility, in a school for mentally retarded) and the geographic area in which the eligible individual resides (upstate/downstate).

New Jersey has no subsidy cap, but wants to change its method of subsidy determination, to reduce complexity and paperwork. A possibility considered is for the Division on Aging to determine a state-wide or a regional cost per unit for each service in the program and a standard salary for the position of coordinator. An individual project would submit a projected budget for the number of residents and the number of service units needed for those residents. The state would then pay a certain percentage (for example, 75%) of the cost of the coordinator and the services based on the state or regionally determined per unit cost. The operator would be responsible for the other 25 per cent through private contributions or other funding.

In four of the five states (Vermont, Maine, New Jersey, and Maryland), each project submits an annual projected budget to the state and is reimbursed quarterly during the year. In these states, subsidy monies flow from the state directly to the sponsor or operator in direct response to the projected program budget which is based on each individual's service needs, other funding sources, and the project's unique configuration of services, delivery methods, and staff make-up. In New York, a program participant will receive one monthly check from the federal government which includes both his computed state and federal SSI grants; and he must turn this payment (plus any assessed participant contribution) over to the project operator, less a very modest personal allowance. In contrast to the other four states' programs, each participant is not charged according to his service plan, but is assesed an identical amount ($705/735) to cover services/rent/board regardless of his service utilization rate and regardless of each project's services/staff/delivery configuration.

STATE	VERMONT	MAINE	NEW JERSEY	MARYLAND	NEW YORK
YEAR BEGAN	1979	1984	1981	1976	1979
DESCRIPTION	Prog. avail. to up to 33% of resid. pop. of pub. sen. housing facilities.	Prog. avail. to up to 20-30% of resid. pop. of sen. hous. facs.	Prog. avail. to up to 25% of resid. pop. of pub. sen. hous. facs.	Prog. avail. to up to 10-25% of resid. pop. of pub. sen. hous. facs.	Prog. avail. to up to 25% of resid. pop. of pub. sen. hous. facs.
OVERSIGHT	Aging Dept.	Aging Dept.	Aging Dept.	Aging Dept.	Social Services Dept.
LICENSE	Demonstration project through AAAs.	Aging Dept.	Not Required	Certified by Aging Dept.	Social Services Dept.
SPONSORS	Private proprietary/non-profit; housing authorities; joint public/private; AAAs.	Joint sponsorship by AAA and local housing developers.	Senior housing; non-profits; limited dividend partnership.	Housing authorities; non-profit organizations.	Private/public non-profits; housing authorities.
SOURCE OF SUBSIDITY FUNDS	General funds supplement Title III community grants	General funds.	State casino revenues.	General funds.	State SSI Supplement.
MONEY FLOW	AAA contracts w/ sponsor or service provider; AAA submits annual projected budget to Aging; Quarterly advance of funds to AAA.	Project submits annual projected budget; quarterly advances from Aging to operator or through AAA.	Formula: varying % of program cost subsidized relative to discretionary income of resid; projected budget sent to Aging; funds paid to operator.	Sponsor submits annual projected budget to Aging; monies sent to sponsor through AAA.	Fed & State SSI funds sent to resid; all pay operator same amount for services & rent.
STATE'S ANNUAL COST	$106,800; cap: $100 per person/mo.	$294,000; cap: $150 per person/mo.	$800,000 No cap	$1.1M; cap: $100 per person/mo.	$1.2M; cap: $365/395 per person per month
CLIENT ELIGIBILITY	62+, frail, but no medical supervision; income: 80% of county median income; private pay w/no subsidy.	60+, below ICF/SNF el.; No fin. el. criteria.	Elderly w/ADL impairments; self-ambulatory; financial el.; discretionary income less than 126% of OMB poverty level.	62+ w/ADL impairment. No financial el.; all in subsidized housing.	65+ w/ADL impairment; 18+ disabled; no continuous nursing; SSI eligible.
# FACILITIES	17 (5 AAA regions)	16	30 (23 operators)	27	51 (25 operators)
# RESIDENTS	89 slots	169	Avg: 590/month	902	382 (600 slots)
STATE'S MONTHLY PROG. COST	$44 per person	$150 per person	$113 per person	$100 per person	$250 per person (est.)
COST SHARING	Sliding scale	Sliding scale	Sliding scale	Sliding scale	Sliding scale
SERVICES	Standard*	Standard*	Standard*	Standard*	Standard*
SER. DELIVERY	Own Staff; contracted	Own staff; contracted	Own staff; contracted	Own staff; contracted	Own staff; contracted
SER. PURCHASED BY RESIDS.	As needed; subsidy paid to operator.	As needed; subsidy paid to operator.	As needed; subsidy paid to operator;	As needed; subsidy paid to operator;	Package; subsidy paid to residents.
STAFF	AAA staff; circuit rider.	Care manager (employee of AAA) part-time staff; vols.	Prog. Coordinator; as needed staff & vols.	Site Coordinator; meal staff varies.	Coordinator; per. care; housekeepers; food service staff.
# MEALS MANDATED	None	1	1	3	1
MEAL DEL. METHOD	Weekdays Title III-C; weekends: staff; contracted.	Title III-C; own staff; contracted.	Title III-C; own staff; contracted.	Title III-C; own staff; restaurant; contracted.	Own staff.
RESID. PRIVATE KITCHEN	Yes	Yes	Yes	Yes	Yes
COMMENT		Will review if $150 per person/mo. is a realistic figure.	Want $1.2M to expand program next year. Trying to change pay procedure to reduce complexity.	10-year eval. due in 1987. Aging Office now giving TA & certification to priv. developers for priv. pay, moderate income elderly.	Program regulations are currently being re-evaluated. Consideration is being given to extending services to non-program residents.

*Standard Service Package: Congregate Meal, Housekeeping, Personal Care, Transportation, Laundry, Social Services.

Are Congregate Housing/Services Programs Cost-Effective Relative to Institutional Care and In-Home Care?

- Comparatively, congregate housing/services per diem costs are substantially less than nursing home per diem costs.
- Congregate programs result in *per person* savings in instances where nursing home patients are transferred to a congregate housing/services program or an individual about to enter a nursing home is diverted, instead, to a congregate program.
- *Aggregate* costs of a congregate housing/services program are greater than net savings from the relatively few averted or transferred nursing home placements.
- Most cost comparisons of congregate housing/services programs with other in-home service programs have been unreliably measured and are, therefore, inconclusive.
- The argument for community-based and congregate services should not be to avert institutionalization, but to enhance the quality of life for a substantial segment of the older population, to serve as a preventive measure for the mental depression common among older elderly, to augment communities' informal support systems, and to mediate the increasing pressures on housing managers.

The issue of cost effectiveness, as it relates to congregate housing, is extremely complex. There is lack of agreement among researchers on a methodology for calculating the cost of congregage housing, and a rigorous framework for analyzing the issue has yet to be developed. Thus, the research produces inconsistent results, and findings are inconclusive. Some researchers view congregate housing as a more appropriate alternative to nursing home care while others view this option as an alternative to the traditional method of providing home care.

There is widespread reporting that providing shelter and services via congregate housing/services is less expensive than providing shelter and services in an institutional setting (skilled nursing facility, health related facility), and states that have instituted a congregate services program couch their justification in terms such as "delaying or avoiding institutionalization in order to provide a more appropriate environment for the elderly and to contain the high costs of institutional care."

Cost comparisons are often stated. For example, Connecticut's congregate program average monthly cost per person is $645 compared to $1,178 which is that state's portion of average monthly medicaid reimbursement per nursing home patient. New York's average monthly subsidy cost per person in the state's Enriched Housing Program is $250 (funded from general funds through the state's SSI Program) vs. $1,042, which is the State's average portion of medicaid reimbursement per nursing home patient. Massachusetts compared the cost of maintaining 114 congregate housing residents with the cost of nursing home care. Twenty one of the 114 had previously lived in nursing homes. The average cost of Level III nursing home care (comparable to congregate-profile service care) for the 21 residents was $1,116 per month and covered nursing, room and board, laundry, recreation, aide services, orderlies, dietary, and administrative staff. Average cost of congregate care for these 21 residents was $880.48 per month and included shelter costs (development and debt service), board, health and social services, management services,

homemaker, personal care, chore, counseling, transportation, and day care.

A 1981 study by the Massachusetts Department of Public Welfare, comparing Level III nursing home care with a HUD Congregate Housing and Services project and a small private congregate project concluded that the annual cost of institutional care in an Intermediate Care Level III Facility would be $9,842, which is $2,400 to $3,500 more per year than the cost of maintaining an individual in either of the two congregate facilities.

Nenno, Nachison and Anderson (1985) cite an analysis in Illinois which found that a full congregate housing/services program could be provided for $10 to $14 a day per person compared with government covered skilled nursing care at $27 a day. Heumann, *et al* (1985) compared costs of seven congregate facilities with the costs of comparable-profile residents of six nursing homes in Illinois and found the average monthly cost per congregate resident to be $623 and the average monthly cost of comparable nursing home residents to be $702.

Thus, some of those residents currently inappropriately placed in nursing homes; that is, requiring a less intensive level of care than is provided in a nursing home could be currently more appropriately cared for in a congregate setting (non-institutional, non-medical, minimum intervention environment) and at a significantly lower cost, supporting the argument for transferring functionally eligible elderly from institutional care into residential congregate programs.

There is conflicting opinion (and no clear data on a national basis) about the proportion of nursing home patients who are "inappropriately placed." Davis and Gibbin (1971) estimate the proportion at 10 per cent. Nancy Anderson (1975), using six measures of competence, found 18 per cent inappropriately in nursing homes, but concludes that only nine per cent could be cost effectively cared for in alternative programs. In 1983, the Minnesota Department of Welfare estimated the figure at 40 per cent (Nachison, 1985), as does Elaine Anderson (1985). A United States Government Accounting Office study concluded that 11 per cent of elderly in institutions could utilize congregate housing (Mass. Final Report, 1984).

Sixteen per cent of the residents in Massachusetts' state funded congregate projects came from nursing homes; 11 per cent of HUD's congregate residents filling turnover slots came from nursing homes; and between 5 and 10 per cent of New York's Enriched Housing Program came out of institutions. This is not the same as saying that 16, 11, or 10 per cent of nursing home patients moved to congregate projects.

The conflicting estimates of inappropriate placements may soon be academic because the Resource Utilization Groupings (RUGs) reimbursement methodology instituted in New York in January, 1986, has increased incentives to nursing homes to reverse their previous admission policies to prefer the heavy-care category patient over the light-care patient in order to achieve higher reimbursement rates. For the period from the institution of RUGs through the summer of 1987, the number of Medicaid patients in New York's nursing homes in the heaviest care category has tripled and the number in the lightest care category has fallen by 24 per cent (Wolff, 1987).

It is easy to mistakenly extrapolate nursing home vs. congregate costs to assume large aggregate service cost savings based on the number of residents in a congregate program. For example, according to Nenno, Nachison, and Anderson (1985), nursing home costs to the federal government averaged $14,510 per person per year while total congregate cost to the federal government averaged $4,589 per person per year. "Thus, the cost of congregate services was only 32 per cent of institutional care." "For

each dollar spent on CHS Program services per participant annually, three dollars can be saved" (Anderson, 1985). The implications of this comparison can be misleading if it is inferred that the government is saving money on all congregate clients. A per person net savings occurs only for those persons in a nursing home or about to enter a nursing home who are placed, instead, in a congregate program.

After evaluating HUD's Congregate Housing and Services program, the conclusion of Sherwood, et al, (1986) was that the most critical variable in making an impact on costs is identifying *when* people are about to make a housing change. Congregate, as compared with institutional care, is only cost effective when you take as residents people who are currently in institutions and who can be relocated to congregate or those in the community who are about to actually move into an institution (Sherwood, *et al*, 1986) (not necessarily those who are merely deemed eligible for institutionalization). Only 20 per cent of those eligible for nursing home care actually enter nursing homes (Sherwood, 1987).

In the HUD Congregate Housing Services Program, an average of three people per CHS Program site were transfers from institutions (Anderson, 1985). This totaled 189 out of 2,200 total program participants, and cost savings can be assumed for these 189 persons. However, three fourths of the CHS program's residents were assessed as "not likely to be institutionalized" prior to program implementation (Sherwood, 1985). Without a congregate program available, these persons would most likely have found alternative community-based or family care. Thus, availability of a congregate program for these persons is not saving the additional cost of institutional care.

The 32 per cent figure stated above is significant only if one can truthfully say that, without the congregate program, clients now receiving the congregate housing/services program would have actually been inappropriately placed in nursing homes and that those congregate clients who subsequently became nursing home eligible would have actually entered nursing homes instead of dying at home, going to live with family, or employing in-home help.

A study by Morris, *et al*, (in press) supports the view that the purpose of housing/services programs is not primarily to reduce institutionalization. The authors compared four housing/services options (case-managed home care, congregate housing/services, age-segregated senior housing with no case managed home care, and age-segregated senior housing with case managed home care) with a control group of seniors living in private homes/apartments with no case management services, utilizing four institutional-risk categories (Very Low, Low, Some, High) to compare days of institutional placement. Analysis found a positive role in providing case management services in congregate and elderly housing settings for those clients in the High risk category. However, case management made no difference in long term facility placement rates or days spent in long term care facilities for those in the Some, Low, and Very Low categories.

A longitudinal benefit/cost analysis (using a control group) of the Highland Heights *medically oriented* congregate program was done over a three year period by Sylvia Sherwood (1981) comparing institutional vs. congregate costs. This program did reduce institutional days. Sherwood defined benefit as societal costs (cost of days in long term and acute institutions) that would have been incurred, but were averted, as a result of the Highland Heights intervention. Translating all dollar amounts into 1977 dollars, Sherwood found that for the 214 resident sample (compared with 214 controls who were matched individuals from the pool of applicants to Highland Heights) the benefit/cost ratio for the three years were 2.83, 2.15, and .62. That is, while the total costs

(housing and services) of maintaining persons in the congregate program was greater each year than the costs of housing and services incurred by the controls in the community, the amount of money saved because of the reduced number of institutional days of the congregate residents (benefits) resulted in a *net* dollar *benefit* of $339,712 the first year, $141,682 the second year, and a *net loss* the third year of $25,971.

Cumulatively, for the three year period, the savings were $445,423 and the *cumulative* benefit/cost ratio was 2.21. These analysis figures apply to following the same initial group of 214 persons over the three year period. If the analysis was done with a constant pool of residents (movers and deaths replaced with new, less impaired occupants), the benefit/cost ratio for the three years was 2.83, 2.29, 1.43, with a 2.29 cumulative benefit/cost ratio over the three years. Thus, in the case of both a finite sample and a constant sample, the benefit in the third year drops dramatically even though the cumulative benefit is still significant. A critical study would be one which determines the number of years before the *cumulative* benefit/cost ratio becomes negative.

Critical in the cost comparison between institutional care and congregate programs is the fact that congregate housing/services programs do not target only inappropriately placed nursing home patients or those about to enter a nursing home. Congregate program subsidies support congregate participants who are non-nursing-home-eligible. Thus, while congregate care is comparatively cost effective relative to nursing home care costs, the argument for the expansion of these programs cannot be made on the basis of absolute savings. The net amount saved for the smaller number of nursing home aversions and relocations is more than offset by the aggregate costs of providing the congregate program for the total number of program participants.

In addition, the agency that pays for the congregate housing/services program is not necessarily the one that accrues any potential comparative savings. Depending upon program participants' income levels, states may pay aggregately more of the lesser congregate costs, which are non-medical and thus not covered by Medicaid except with special waivers. States' revenues normally subsidize state-sponsored congregate housing/services programs while the federal government contributes to the more costly nursing home costs at a 50/50 split. In transferring residents from nursing homes to congregate, there may be a significant shift in cost coverage from federal to state programs. Several examples: In Massachusetts (Mass. Final Report, 1984), for 20 cases of transfer, federal payments were 31.5 per cent of patient costs when the 20 were nursing home residents, but were 8.5 per cent of patient costs when the 20 were in congregate. The state's portion of costs went from 31.4 per cent when the 20 were institutionalized to 77 per cent when they were placed in congregate. Residents' contributions to costs included SSI, social security, and pensions, and are, therefore, primarily income from federal programs. If residents' contributions are added to federal program payments, the federal/resident portion is 68.5 per cent while in institutions and 22 per cent while in congregate.

Mass. 20 cases	Fed.	Resid.	Fed./ Resid.	State
Instit. Care Paid:	31.5%	37%	68.5%	31.4%
Congre. Care Paid:	8.5%	13.4%	22%	77%

In Illinois, the "sheltered care" (lowest of three levels of institutional nursing care, characteristic of those residents most easily transferred to congregate housing/services programs) reimbursement rate is kept low and new sheltered care beds are slow to be approved because sheltered care is entirely reimbursed through state general revenues and not split with the federal govenment as

are intermediate and skilled nursing care costs (Heumann, *et al*, 1985). In New York, the Enriched Housing Program, which offers a core set of services to seniors in well-elderly apartment buildings, is classified as a Residential Care Facility, with the service package reimburseable through the state's SSI subsidy program which is funded from the state's general revenues.

The federal government may pay a major portion of costs in instances where congregate housing/services residents are very low income and are, therefore, eligible for federal SSI, federal rent subsidies, Title XX and other entitlement programs, or where congregate programs are granted Medicaid waivers.

Congregate housing is not cost saving if compared to other age segregated community-based housing/services alternatives or in-home care (Sherwood, 1986). Some argue, however, that any cost comparisons are misleading because too many confounding variables compromise results. For example, studies will use empirically based utilization patterns and cost estimates instead of actual data; use actual data for experimentals, but estimated data for controls; use no controls; use non-standardized definitions. Surveys will lack participant randomization, or will compare projects with dissimilar configurations of variables, residents or purposes. Research will cover short time periods; variables will not be held constant among programs. Resident charges vs. program costs are not always adequately identified, nor is the source of payment adequately distinguished or consistently factored in. Meaningful cost comparisons between congregate housing/services programs and in-home programs would have to take into account the mortgage and debt service costs of a private residence, repair and upkeep, utilities, food, transportation, and medical care (Pollack, 1976; Dellinger, 1975). Meaningful comparisons should be made without regard to who pays the bill and should include in-kind assistance by volunteers, family, and friends, and include lost opportunity costs. In addition, levels of client disability grossly affect the cost of community care, as does the quality of care delivered. Good care costs more than bad care, and cost studies do not deal directly with this issue (Lawton, 1978).

Thus, the issue of cost comparison is a murky one. What is clear, however, is that the number of older adults, particularly those 85+, will continue to increase into the next century, making present long term care alternatives inadequate for the number of frail elderly that will require shelter and services. Donahue (1981) estimated that three million semi-independent persons 65+ could benefit from congregate housing. Thus, any service program will create its own demand. Congregate housing/services is not a substitute for skilled nursing care. Institutionalization would not be averted, but a network of congregate and in-home programs would serve those who would not be candidates for institutions. In New York, with the current nursing home need methodology, nursing home beds will always be filled at their present full capacity with those elderly requiring the skilled nursing level of care; and congregate programs can continue to expand to serve the increasing number of older adults who will require assistance for continued independent living.

The argument for community-based and congregate services should not be to avert institutionalization, but to enhance the quality of life for a substantial segment of the older population, to serve as a preventive agent to the development of the mental depression commonly found among older elderly, (Lawton, 1978; Donahue, 1981), to augment the efforts of the growing number of families that constitute the vast informal support system currently in place to support semi-independent older adults, and to mediate the pressures felt by housing managers from the increasing demands placed upon them by the significant number of aging tenants with service needs.

Costs

- Housing (rent and utilities) is the major cost of a congregate housing project.
- The consistency of demand for housekeeping services among congregate residents argues for cost efficiency in including this service in the monthly fees, while cost of meals should be offered at a per meal fee as meal service preference is so diverse.
- States have no refined methodology for determining the optimum resident number, case mix, or level of service to achieve cost efficiency, but thus far have based subsidy reimbursement on one or two demonstration sites or an average of service costs across the state.

There is agreement in the industry that the major cost of congregate housing is the cost of the housing itself (for example, while the average of shelter and services per person in Massachusetts' state funded congregate housing program was $1,001.15 per month, housing represented $619.21, social and health services represented $239.26, and administrative costs represented $142.68). Beyond that agreement, research review and industry experience merely conclude that services are expensive and difficult to formulate into generalizable cost-efficient configurations. Cost analysis by Malozemoff's (1978) 27-site survey showed an association between financial stability of the project and the number of services included in the monthly fees, with sites providing the fewest services having the most positive financial status, and those with higher service levels almost uniformly operating at deficits, with food and medical services the most costly items.

In evaluating the Department of Housing and Urban Development's Congregate Housing Services Program, Nachison (1985) found that, dependent upon the number of residents, part-time staff was often sufficient to implement the program. The evaluation also found that the Congregate Housing Services Program must target service delivery on a "needs" philosophy and not a "wants" philosophy (that is, target those most at risk) in order to be cost efficient, that substituting program services for already existing community resources should be prohibited, that programs should focus on existing housing and use cost-sharing fee scales, and that groups of buildings in the same neighborhood achieve economic efficiency by sharing management, meal delivery, and in-home services.

Tell and Wallach (1984), in their study to determine cost variations among Continuing Care Retirement Communities, found that costs per resident had a systematic relationship to the proportion of residents in nursing care, location in a high wage or urban area, and the facility's tax status; and that while the impact of utilization-to-capacity was seen, the impact was quite small.

The service most used by congregate residents is homemaking/housekeeping. The consistency of demand for housekeeping argues for cost efficiency in including this service in monthly fees, while, as Malozemoff (1978) argues, since preference for meals is so diverse, cost of meals should be offered at a per meal fee.

Malozemoff, *et al*, (1978) found that the setting of monthly rates in any one project was not associated with the level of services provided, that after a minimal provision of services, cost increments of providing high rather than medium service is not significant. It is futile to think in terms of economies of scale in relation to a particular project because any one congregate project will usually be small in size, requiring the basic outlay required to operate any program. The benefits of utilization-to-capacity

may be possible with multiple sites within a geographic area which would allow sharing of staff and equipment and permit larger service contracts. This arrangement may compromise quality control of service delivery and reduce staff/resident interaction. Human service industries must always contend with a variable which manufacturers need not consider; that is, maintaining a balance between cost efficiency and cost effectiveness. The most cost efficient human services program may not be the most appropriate for clients. While manufacturers strive for least cost per unit of identical output (efficiency), human service program operators strive to identify a program which will maximize service per unit cost in an *appropriate manner for clients* (that is, achieve the desired, often unmeasureable, outcome) relative to alternative *appropriate* programs (effectiveness).

According to Knapp (1978), one can determine how the costs of care will vary with the size of the home, the number of residents, dependency level of residents, and changes in resident well-being and behavior. Knapp states that the average cost curve of residential care services is U shaped; that is, cost per unit goes down as output increases and then rises again because of necessary increased administrative costs and the strain on the use of fixed equipment. Applying this to state-wide programs, determining the configuration of variables for each project's population within a geographic area will presumably determine the optimum size to be served for greatest cost effectiveness in that area. The difficulty here is that residents (units of output) are not static. Once the program is filled with residents determined to be a cost effective number and mix, the dependency variable will change continuously, affecting the cost of the program.

The difficulty in determining a cost effective formula is reflected in industry practice. The Malozemoff survey found that the development of service level was arrived at arbitrarily at 25 of the 27 sites surveyed, the operators offering what they thought "should be" provided rather than providing services based on a preliminary analysis of the target population and area costs. In a review of states' subsidized programs, initial cost parameters were set based on one or two small demonstration sites. Many of these states are now reviewing these spending caps because there is evidence they do not realistically reflect current costs.

Resident Profile

- Predominately female.
- Widowed, divorced, single.
- Average age: early 80's.
- Low income population in publicly sponsored programs; moderate/upper income in private programs.
- Residents come from the area surrounding the congregate facility.
- Residents view the environment as a residential option, not a level of care.
- Motivations for choosing a congregate housing/services facility: affordable, safe environment, social opportunities, continued independence, accessible services.

Surveys indicate that as the proportion of older residents in age segregated housing/ services projects increases, the proportion of females increases, which parallels national female/male ratios.

The ratio of females to males was 80/20 in Malozsemoff's (1978) national survey of congregate programs, and 48 per cent of the residents were 80 years of age and over. Mor (1986) quotes several descriptive survey sources which indicate a 70/30 F/M ratio, with 30% of residents over 80. Mor's (1980) own survey of residential care programs found 67 per cent female and 42 per cent over 75. Massachusetts' state-sponsored congregate program ratio of F/M is 61-39. However, 44 per cent of the men were 65 to 74 years of age, while 43 per cent of women were 75-84 years of age (Guidelines, 1984). Surveys and discussions with congregate facility managers indicate that the average resident age has increased over the years, reflecting several trends: the aging-in of long time residents due to increased longevity, consumers' availability of in-home services extending independent living in private homes/apartments and delaying relocation to supportive-service congregate environments, congregate applicants entering congregate facilities at later ages, and the trend of congregate facilities for providing a more intensive level of care and thereby allowing residents to remain in the congregate project longer. The proportion of male residents is also increasing, reflecting a greater acceptance among emerging older cohorts of congregate living as an alternative living environment.

Lawton, *et al*, (1980) suggests three factors that account for the environmental image of a housing/services project: (1) administrative policies which impose strict behavioral and health admittance standards; (b) administrative policies which strictly adhere to discharge procedures; and (c) self-screening by potential tenants who base their decision to enter a congregate facility upon whether the project's current character matches their needs and preferences.

Ninety four per cent of the residents in Malozemoff's national survey had annual incomes below $12,000, with the majority having incomes of $6,000 or less. The Mor survey of state-sponsored programs did not document income levels, but one fourth had 100 per cent SSI recipients and half had 26-99 per cent SSI recipients as residents. Most state-sponsored programs target low/very low income elderly since the purpose of these programs is to provide a less costly alternative to those who may ultimately become eligible for more costly higher levels of subsidized care.

In the general community, 28 per cent of men aged 75+ and 76 per cent of women aged 75+ are single (SB Statistical Bulletin, 1984). Ninety four per cent of the residents

in Mor's survey were single, widowed, divorced, and 97 per cent of Massachusetts' congregate residents were single or widowed. Ninety per cent of the men in Mor's sample and 95 per cent of the men in the Massachusetts study were single. Elderly married couples provide informal care for each other (Tell & Wallack, 1984), live in their own homes, have higher income, suffer less insecurity and loneliness, and maintain an independent style of living longer than single older adults.

Congregate facilities report that the great majority of their residents come from the surrounding area. The Massachusetts study shows typical results: 77 per cent of residents came from the same community as the facility or a community adjacent to the facility. Only 3 per cent came from outside Massachusetts, most of these coming in order to live near a family member. Eighty five per cent of Massachusetts' congregate residents have a family member within a 20-mile radius of the facility. Referrals are made by local service providers, family members, or are self-referred.

Potential residents do not view a congregate housing/services facility as a housing option that is different from conventional housing (Malozemoff, *et al*, 1978; Johnson, 1985). Relocation to a congregate facility is not seen as the final move and, therefore, is not as traumatic as a move to a nursing home.

People move to congregate housing for various reasons. The affordable cost is important to widowed and single people, urban dwellers, renters, low income elderly, and Blacks (more have low income). The security inherent in a safe building, being part of a group, and having the presence of program staff is important to single women, frail elderly, urban rooming house residents, and low income persons and urbanites moving from deteriorating neighborhoods. For displaced urbanites who have lost their homes/apartments in rehabilitation projects, or suburban and rural homeowners who can no longer afford the repair, upkeep and taxes, a congregate facility may be the only viable option, and simply represents shelter.

The convenience of services is attractive to middle class persons and over-housed suburbanites who wish to escape the costs and burdens of home ownership. The availability of services is important to widowed men who are unused to caring for themselves and to the more affluent who view services as a convenience, not a necessity. In Malozemoff's (1978) survey of 27 facilities (including six Continuing Care Retirement Communties), 37 per cent of residents were married. This percentage is much lower in publicly funded congregate facilities. When married couples move into a congregate facility, they cite health problems, difficulties in keeping up their homes, and climate as reasons for relocation.

Older, isolated, frail, single or widowed persons, particularly women, cite loneliness as the reason for moving to a congregate housing/services facility.

In the Malozemoff survey, 22 per cent listed "hard to keep up home/apt" as their *primary* reason for moving from their previous residence. Seventeen per cent moved primarily because they were "concerned about becoming a burden/wanted to maintain independence." Eleven per cent could not afford to stay in their previous homes. "Health reasons" was ranked by only nine per cent as their *primary* reason for moving. As to choosing a congregate facility instead of another alternative, the first reason for 16 per cent was that the facility was "closer to family and friends." Nine per cent said the facility was "in their home town." Eight per cent listed, as their first reason for choosing congregate, "independence and flexibility" in life style; 7 per cent picked "food and other services;" and 6 per cent cited "the medical program" as their first reason.

In general, younger residents were not seeking the age specialized design of

congregate facilities (Sherman, 1971; Malozemoff, 1978), nor was the availability of support services or meals a strong determinant for their choice. For younger residents, the decision to move to congregate was based on the location of the facility and a preference to remain independent in the community. For waiting list applicants, "the medical program" ranked 14 out of 15 as an attractive reason to move to a congregate housing/services project, and "food and other services" ranked tenth. As the age of potential residents increased, declining health status increased as a reason for moving into a congregate facility and an on-site health program increased as an attraction, but still was not the prime attraction in choosing a congregate facility.

Reasons For Choosing Congregate Housing
Residents and Applicants

REASONS	RESIDENTS		APPLICANTS	
	1st Reason %	All Reasons* %	1st Reason %	All Reasons* %
Special design features for maneuverability	2.0	18.0	2.4	16.9
Closer to stores, transportation	7.0	27.0	10.6	39.7
More people to be friends	5.0	27.0	8.2	34.9
In safe neighborhood	2.0	12.0	0	19.3
Alarm system for emergency	2.0	13.0	0	9.6
Physically better/more attractive	6.0	16.0	2.4	12.1
Closer to family & friends	16.0	33.0	20.2	49.4
Food and other services	7.0	35.0	2.4	28.9
Variety of activities	1.0	10.0	1.2	19.3
Medical programs	6.0	22.2	1.2	14.5
In home town	9.0	28.0	13.0	38.5
Reasonable cost	7.0	12.0	7.0	10.8
Management friendly	3.0	3.0	0	8.4
Only place to go	5.0	7.0	1.2	4.8
Independence/flexibility	8.0	12.0	13.2	19.3
Forced by family	2.0	2.0	0	0
Church-sponsored	4.0	7.0	5.2	9.2
Climate	4.0	7.0	5.2	9.2
Other	4.0	7.0	5.2	9.2
TOTAL	100.0% N = 469		100.0% N = 83	

*Duplicated count: This column total is greater than 100%

Housing for the Elderly: Evaluation of the Effectiveness of Congregate Residences (Malozemoff, Anderson, and Rosenbaum, 1978)

Reasons For Moving From Previous/Present Residence
Residents and Applicants

	RESIDENTS		APPLICANTS	
	1st Reason %	All Reasons* %	1st Reason %	All Reasons* %
Distance from family/ friends	5.0	8.0	11.1	8.0
Unsafe in neighborhood	6.0	13.0	2.3	13.0
Concerned about emergency	7.0	24.0	11.7	24.0
Couldn't afford to stay there	11.0	19.0	9.4	19.0
Access to community difficult	2.0	13.0	4.7	13.0
Hard to keep up home/apartment	22.0	42.0	12.9	42.0
Family encouraged move	7.0	23.0	3.5	23.0
Health reasons/Doctor's orders	9.0	14.0	4.7	14.0
independence/concern about being a burden	17.0	21.0	35.2	21.0
Home torn down	4.0	5.0	0.0	5.0
Lonely	5.0	7.0	1.1	7.0
Climate	1.0	2.0	1.1	2.0
Other	4.0	8.0	2.3	8.0
TOTAL	100.0% N = 469		100.0% N = 85	

*Duplicated count: These column totals are greater than 100%

Housing for the Elderly: Evaluation of the Effectiveness of Congregate Residences (Malozemoff, Anderson, and Rosenbaum, 1978)

Services

- Core package of services in traditional private congregate housing/services projects: one congregate meal, scheduled transportation, housekeeping, laundry, 24-hour emergency response.
- Core package of services in state-sponsored congregate programs: all of above plus social services and personal care services.
- Congregate services programs do not include chronic nursing care.
- Congregate project service used most by residents: homemaking/housekeeping.
- Publicly subsidized congregate programs often mandate no duplication of existing community services.
- Number and intensity of services available in a program reflect management's view of elderly persons as independent/dependent and defines the population to be targeted.
- Service delivery by project staff vs. contracted providers is a function of rural/suburban/urban location, with close proximity to community services associated with increased use of contracted providers.
- The overwhelming majority of congregate housing/services program residents do not relocate to institutions, but remain in the congregate facility until death.

Laws vary from state to state regarding the provision of medical services and licensure. In New York, private congregate housing/services projects do not require licensing as long as the operator does not directly provide personal care or health related services or does not include the cost of personal care services in the residents' monthly charges. The operator may assist a resident in contracting individually for health services through a private physician, hospital, clinic or home health agency. A sponsor may even locate a congregate housing/services project on the same campus site with a medical clinic, nursing home, or hospital and have arrangements with these facilities to care for the congregate residents. An operator may have an RN on staff for emergency intervention. However, if the congregate project's staff directly provides hands-on personal care services or if the personal care component is included in the monthly fee as part of the service package, the project must be licensed and regulated as an Adult Residential Care Facility (Adult Home) by the New York State Department of Social Services. Confusion between adult homes and congregate services projects arises because the range of residents' functional profiles in both types of facilities are the same. The range of services available are also the same. The methods of service delivery and resident payment for personal care services distinguish the two. Thus, New York's Enriched Housing Programs, which provide personal care service and include the cost for this service in the residents' monthly charges, are licensed by the New York State Department of Social Services as Residential Care Facilities.

The core package of services in congregate housing/services facilities includes one congregate meal a day, scheduled transportation, housekeeping, laundry, and 24-hour emergency response. In private proprietary congregate housing projects, the number of meals, hours of housekeeping, mode and flexibility of transportation, and diversity of recreational activities vary from project to project; and this diversity is reflected in the monthly fees charged to residents. The configuration of services also reflects the project's

management philosophy. If a sponsor views the elderly as healthy, independent individuals, he may offer only one congregate meal, make that meal optional, limit transportation to emergency situations, refer to housekeeping as maid service, encourage active recreational activities, and take no part in brokering in-home care for residents. This sponsor may feel that impaired elderly detract from the project's marketability; and eligibility for entrance will be restricted to younger, healthy, very mobile older adults who view the services as a convenience and who move to a congregate project for the social benefits or to escape the burdens of home ownership. These sponsors, and the project's residents, may be adamant about residents leaving when impairment compromises independence.

Older non-profit projects that began with a similar view have witnessed the gradual impairment of their residents who have aged in place and who are reluctant to move. Managers in these facilities have gradually increased and added services to accommodate the changing profile of their residents. Additional congregate meals and transportation are provided, and personal care is made available through a management contract with a community home health agency, or brokered by management on behalf of individual residents through various community agencies. Some projects maintain an RN on staff for emergency, intermittant nursing care or crisis intervention. A social worker may provide case management, counseling, and coordination of social activities.

Malozemoff's (1978) nationwide survey of congregate facilities found 59 per cent offering personal care services and 41 per cent offering no personal care. Proprietary facilities will stop short of allowing on-going in-home nursing care, as continued nursing care changes the character of the project.

Public congregate housing/services programs, because they are publicly subsidized, target frail, at-risk, low income elderly. Congregate meals, transportation, housekeeping and 24-hour emergency response are provided, but social services and personal care services are also an integral component of the core service package since mental or physical functional eligibility criteria for admittance to the programs mandate that residents require a certain level of assistance with activities of daily living. Financial eligibility criteria for subsidies require that residents be below a specific income ceiling, and this dictates that another required service of public programs be assistance in accessing other eligibility programs in the community such as food stamps, medicaid, SSI, Title XX, etc.

State and federal subsidized programs are very careful to mandate that congregate programs not provide overlapping or duplicative services but, rather, act as a supplement to fill gaps in services and coordinate the delivery of existing services. New York's Enriched Housing Program is atypical in providing a congregate services program which provides the core services, including personal care, and utilizes other existing programs as a supplement to the congregate program.

The services of a congregate program are such that very few public and non-profit congregate residents move to a nursing home. A few move back with families, and a few move to acute care hospitals and subsequently die there, but the overwhelming majority remain in the congregate facility until death.

Congregate housing projects supply their own staffed services in direct proportion to distance from community services. Urban sites rely on the community for provision of services to a greater degree than suburban sites, with rural sites (greatest distance from available services) utilizing the lowest proportion of community services.

There is a relationship between accessibility to community services and

management's attitude about the target population's independence (Malozemoff, 1978). Operators who strive to continue residents' independence will locate within walking distance to services or near convenient transportation. Location is less of an issue for operators who feel the population is dependent because management assumes the responsibility for provision of necessary services. Transportation, at varying levels, is provided in all state subsidized programs since the need for transportation assistance is characteristic of the targeted frail populations in those programs.

The formal service most used by congregate program residents is homemaking/ housekeeping (Mass. Final Report, 1984). Residents view housekeeping as an essential service and use this service to the maximum, purchasing it independently if not available through the program; the demand for housekeeping is stable and constant across sites (Urban Systems, 1978). There is no consistent association between resident income level and use of housekeeping.

Program staff hired specifically for the congregate program participants develop a personalized relationship with the group as a whole, see them on a daily basis, become prime movers of group activities, and become an intimate part of congregate life. Staff hired through sub-contract and assigned to individuals are less involved with group life and do not consider residents' interrelationships to be of professional concern (Mass. Final Report, 1984).

Discussions with project managers indicate that a growing problem is emerging regarding the home health industry. Demand for home health, personal care and homemaker aides has outstripped supply, resulting in problems in service availability, quality control, and staff consistency. In some areas, the local political situation dictates agencies' service turf, leaving consumers with little choice. In an effort to resolve these problems, one congregate operator is contracting with a home health agency to locate an office within the congregate facility and assign a constant group of aides to the facility's residents.

Meal Program

- Congregate programs provide congregate meals several ways: prepared on site by program staff, use of Older Americans Act Nutrition Site Programs, contracted with commercial food services, and contracted with local institutions.
- For the congregate program payor, the least expensive method of delivering meal service is to designate the facility an OAA Nutrition Site (federally subsidized meals).
- Survey results on best methods for providing and serving meals are inconclusive.
- A review of the literature finds conflicting research results regarding older adults' preferences about meals.
- Many variables affect patterns of congregate meal use: age, agility, sex, marital status, ethnicity, income, quality of service.
- There is policy mismatch between program developers and gerontologists on one hand who see social and nutritional benefit to congregate meals, and the elderly themselves on the other hand who prefer cooking and eating in their own kitchens until age and impairment make this activity impossible.

It is difficult to categorize patterns of meal use because many variables affect usage, and a review of the literature and discussions with program managers find conflicting conclusions regarding the preferences of older adults.

Different eating alternatives are preferred by residents as changes occur in age, health status, and physical agility. Increased age and decreased agility bring an increase in the proportion of residents who use the congregate meal program exclusively and bring an increase in the proportion who eat with family and friends. However, Malozemoff's (1978) survey found a distinction between agility and health status, with no association reported between declining health status and increased use of meal programs. It is thought that decreased health status brings an overall disinterest in eating. Single men are more apt to use the meal program, as a convenience. A greater proportion of couples cook for themselves in place of congregate meal service. The greater majority of older adults prefer taking the main meal of the day in the congregate hall, which can be either lunch or dinner; most do not eat an actual breakfast, preferring coffe/tea and a muffin/toast. New entrants to a facility use the common meal to make friends; continued use of the congregate meal as a social function decreases as the resident establishes a social network.

Income levels affect meal program usage. Low income elderly cannot afford restaurant visits, and their use of discretionary funds is directly affected by the inclusion of meal costs in monthly charges. For these persons, preferences cannot be exercised. However, in Prosper's (1985) survey of the Continuing Care Retirement Community industry, where residents had enough discretionary income to exercise eating options, there was a definite trend to including only one congregate meal a day in the monthly charge.

While some sites find younger, agile residents preferring their own kitchens and eating in restaurants, others find that younger, agile residents use the meal program as a convenience in order to increase the amount of free time available for leisure activities. Powell Lawton's research (Thompson & Donahue, 1980) showed that residents wished to make their own meals in their own apartments and would not necessarily be regular program customers if participation in the meal service

were optional. On the other hand, the International Center for Social Gerontology (1978) found that "...experience indicates that tenants who do not need the meal service will avail themselves of it as a convenience and will pay the full cost."

The quality of the food, the elegance of the service, the environment of the dining hall, and the desire for ethnic foods affect usage of the meal program. The health status of the facility's resident population also has an impact. Managers find it takes a great educational process to achieve the acceptance of highly impaired residents in the dining room by those who are less impaired. Other managers consciously segregate diners by functional ability.

The Malozemoff (1978) survey found that availability of meals was not a significant determinant in residents' decisions to choose a congregate facility. Generally, residents viewed the on-site meal service attractive as a convenience, but not as an essential service. However, once in the facility, 72.5 per cent of the surveyed residents used the meal service once a day or more; and, in general, Malozemoff found a preference for a two-meal per day program. A significant proportion of residents defaulted on at least one meal per day at sites requiring three meals a day, but some residents were purchasing additional meals at sites requiring only one meal a day.. However, in discussing HUD's required two congregate meals a day in its Congregate Housing/Services Program, researchers state that this could be reduced to one daily meal without hurting residents (Housing the Elderly, 1985; Bokser, 1986). In response to the program's evaluation results, HUD intends to change its CHSP requirement of two congregate meals a day to one meal a day, with resident option to take more than one congregate meal.

The Department of Housing and Urban Development's 1970 congregate housing initiative allowed the construction of congregate facilities with or without private kitchen facilities (but including central kitchen facilities) and, therefore, mandated that residents take two congregate meals. Recently, HUD was subject to lawsuits by Section 202 facility residents who objected to the mandated 14 meals a week requirement, and HUD recently changed its regulations to prohibit mandatory meals in any new Sections 202 and 221 facilities and Section 8 programs, but will allow any currently existing mandated meals programs in existing facilities to continue (Harris, 1986; Nachison, 1987).

A review of the literature also finds disagreement as to which daily meal is preferred to be taken in the congregate setting. According to Donahue and Thompson (1980), experience indicates that the congregate meal is preferred in the evening by most residents. However, some projects offer the congregate meal at mid day based on residents' expressed preference. As people get older, many shift the major meal of the day to noon time because of declining ability to digest a heavier meal in the evening and the interference this causes with sleeping patterns.

There is a relationship between the number of meals in the program and management's attitude regarding the dependence of the residents they are trying to attract (Malozemoff, 1978), but there is not always congruence between the intended target population and the resident group actually admitted. Irregular patterns of meal usage and changing preferences with changing resident profiles argue strongly for flexibility and choice in providing meals in congregate programs.

There is agreement that meal service is by far the most costly component of any congregate service program. Two mandated meals a day, seven days a week, accounted for 54 per cent of HUD's program costs. Meals accounted for 34 per cent of service costs in Connecticut's congregate housing projects. In the Malozemoff survey, meals were 53.9 per cent of "medium service"

facilities and 48.2 per cent of "high service" facilities. In Heumann's (1985) analysis of seven congregate facilities in Illinois, food service accounted for an average of 33.5 per cent of total expenses, with food costs in two facilities providing 20 meals per month accounting for 25 per cent and 31 per cent of total expense, one facility providing 25 meals per month averaging 30.5 per cent on food service, one facility providing 52 meals averaging 30 per cent, two facilities providing 60 meals per month averaging 41 and 46.5 per cent, and food costs in one facility providing 90 meals per month accounting for 32 per cent of total costs. Beyond that agreement, there is conflicting data and opinion regarding other aspects of meal service cost. The configuration of paid/volunteer/part-time/professional/unionized staff, facility location, number served, utilization of other community services, resident profile, delivery method, and menu make-up uniquely affect each project's total meal cost.

Personnel is a major component of the meal cost. A greater proportion of residents requiring assistance in eating, special diets, tray service, and assistance in getting to and from the dining hall will have an impact upon the number of staff required. Less menu choices and menu changes and cafeteria style service instead of family style would require less staff time, as would less elegance in table cloths, silverware and table decorations used.

If the residents are completely self-ambulatory, the per unit cost of a meal does not fluctuate greatly with the addition of more residents until the number increases enough to require adding to the basic staff.

Malozemoff, *et al*, (1978) tabulated unit costs of meals against volume ranging from 50,000 meals served per-year to sites serving 300,000 to 350,000 meals per year. They found only a weak tendency for lower costs at higher volume. The heavy staff costs of meal services allow for low marginal cost per meal relative to average cost per meal. Sites could shift volume significantly without affecting unit costs, except for raw food costs. However, that analysis may hold true only when dealing with very high numbers and may not be applicable to congregate programs which operate in discrete locations with small numbers of residents.

For small operations, a critical cost element is the degree of utilization at which a project is operating relative to the project's total capacity to operate. Any size program requires an initial outlay for fixed costs (equipment and space, etc.) and a minimum number of personnel (cook, servers, cleanup, etc.). As the number of residents served increases, approaching a project's capacity to serve those residents without requiring an increase in fixed costs and personnel, the per unit cost of the meal service will decrease. Very small congregate projects do not operate at capacity and, hence, do not operate cost efficiently. Opening a congregate project's meal service to non-program participants would allow a program to operate at capacity, as would sharing staff, equipment, and food purchasing between several projects within a geographic area.

The Department of Housing and Urban Development's Congregate Housing and Services Program found that a significant number of their participants were assessed as not "needing" two congregate setting meals. Mandating that the program include 14 congregate meals a week for all program participants cost HUD for congregate meals which many participants did not "need." The CHSP evaluation suggested that congregate meals should go only to those whose functional level requires them. However, providing congregate meals for a limited number of persons raises the utilization/capacity question for small projects. A survey of Continuing Care Retirement Communities supports this concern. Prosper (1985) found that CCRC operators found most residents wanting only one congregate meal

per day and operators finding it economically unfeasible to provide a second and third meal for only a quarter of their residents. Lawton (Thompson & Donahue, 1980) suggests that making all meals mandatory would screen out application by relatively healthy people, thus overloading the resident population with impaired persons. Very few programs require participants to pay for all three daily meals. A common practice, to promote financial feasibility and to respond to residents' preferences, is to require residents to pay for a certain number of meals per week or month, then requiring advance notice from residents of which meals they will attend.

Meals are provided by a variety of methods. The most economical method *for the congregate program payor* is designation of the congregate housing facility as an Older Americans Act Title III-C community nutrition program meal site because that program is underwritten by the federal government. When that is not possible, projects will have meals catered to the project from a nearby OAA site, or purchase meals from a commercial food service or from a community institution such as a hospital which is already preparing meals in bulk, or purchase and prepare food on site utilizing the project's staff. Two of Connecticut's congregate projects which provided one meal per day through the OAA Title III-C program averaged a monthly meal cost of $89 per person compared to a third project's average monthly meal cost of $110 per person which did not use the Title III-C program.

There is disagreement about cost comparison of site-staff preparation vs. contracted food service. Nachison (1985) uses the Ruchlin and Morris study to say that where projects hire staff rather than contract for services, savings have been substantial. On the other hand, Malozemoff, Anderson and Rosenbaum (1978) surveyed 27 sites and found that 19 provided 13-21 meals per week and 3 provided 6-12 meals per week. Sixteen sites reported unit costs: ten prepared meals in-house (including four which were Title III meal sites) at a unit cost of $.71 to $2.04; six contracted out for meal service at a unit cost of $1.04 to $1.97. The average cost of in- house/contracted meals was $1.31/$1.29.

Heumann (1985), for comparison purposes in his survey of seven congregate facilities, translated congregate meal costs for each facility into 90-meal-per-month programs and found on-site food service per resident per month for four sites ranged from $209 to $234, while two facilities with combination caterer/on-site service cost $174 and $224, and one facility with a for-profit catered service cost $199. However, factors complicating the comparison include: cafeteria vs. restaurant style service, differences in the number of entrees, choice of portions, and number of residents in each facility.

The question of site-staff preparation vs. catered meals via the Nutrition Program or similar sources is also a subjective quality-of-life issue. Purchasing, preparing, and serving meals by the project's own staff provides meals by someone who comes to know the food likes and dislikes of the resident population. Staff can also incorporate ethnic diversity, include resident input into menu items and flexibility into meal times, and accommodate creativity in planning. Thompson (1980) compared a $2 catered meal with a $2 site-prepared meal. For the same price, the site-prepared meal included 15 choices within six categories vs. the catered meal's five choices within five categories. Thompson suggests that the outlook of a continuous diet of the average catered meal year in and year out is dismal. Nachison (1987) counters that the crucial variable is quality of the caterer, saying that the HUD Congregate Housing and Services Program's experience with caterers has been

generally positive because the quality of the food service vendor has been good.

Of the two principal types of meal service, cafeteria style service may be cheaper than family style service because it decreases staff costs and, at the same time, may provide a wider range of choice in food selection (Thompson & Donahue, 1980). However, the decision on service style depends on the functional characteristics of the residents and the availability of volunteer staff to reduce costs. Some residents may not be able to handle a tray in addition to a mobility aid; certain degrees or types of frailty may cause apprehension and spillage; those in wheel chairs may not be able to see or reach the food, requiring dependence on others that would not be necessary if seated for service.

Tray service (delivering meals to a resident's room) is an expensive item, requiring more staff time, and is generally offered only for temporary periods of time and on a doctor's orders.

Kitchens

- Women residents prefer to have a private kitchen.
- Kitchens are not an issue for widowed men.
- Kitchens become less of an issue for residents who are 85+ and very impaired.
- Kitchens and larger sized units are important to lower income residents as they serve as their center for social activity.
- Kitchens serve to maintain residents' independence and privacy.
- Occupancy is hard to maintain in units with no kitchens.

Both the congregate housing/services industry and its more affluent version, the Continuing Care Retirement Community industry, learned through experience that older adults prefer to retain their kitchens as a component of their living units and, until impaired, prefer to eat in their own apartments. Eighty nine per cent of Thompson's (1975) survey of senior housing residents recommended individual kitchens.

Residents use kitchens to prepare snacks, prepare breakfast and/or lunch, cook for friends and family, maintain a private stock of food, cook ethnic or religious meals, and cook meals "their own way" (Thompson, 1980). Even residents who do not have a refrigerator or eating utensils in their rooms have a shelf or table for snacks, and almost all residents entertain family and friends in their own rooms rather than in common spaces (Mass. Final Report, 1984). The great majority of congregate housing residents are women, and managers find that women want a full kitchen. However, most male congregate residents have never cooked for themselves and do not consider the kitchen issue an important one. Younger elderly want a kitchen; for those 85+ who suffer from chronic or severe impairment, the congregate meal service becomes more attractive and the kitchen is less useful.

Congregate housing is described as an elderly housing alternative, not a level of institutional care. Institutions are defined in terms of "beds," while congregate housing is defined in terms of independent living units. The home-like environment (which includes a kitchen) of a congregate housing/services project is one of its great advantages over an institutional setting. The availability of kitchens enhances the flexibility and control of one's life because congregate meals, whether in congregate housing or institutions, dictate when, what, and with whom one eats. Elimination of the personal kitchen shifts the character of the living environment from home-like to institutional. It removes a component which symbolizes, and in reality is, a source of independence, and one which is critical for maintaining a sense of privacy.

A common complaint about shared apartments centers on the kitchen turf issue: which food belongs to whom, equal division of shelf space, compromises on use-time, dissatisfaction over sharing of cleaning chores. Turf is not as much an issue in a group family residence as the kitchen is acknowledged as belonging to the family group. However, in a two-person shared apartment, the initial occupant establishes ownership of the kitchen.

The Malozemoff (1978) survey of congregate-type facilities found a direct relationship between the provision of kitchens and management's targeted population (perceived frailty/dependence). Managements' perceptions, however, have not always matched residents' preferences. Many Continuing Care Retirement Communities that began with kitchinettes have replaced them with full kitchens to satisfy resident complaints

and to enhance marketability. The trend in newer state-supported congregate projects is to include full kitchens. Of 15 state-supported congregate housing/services programs reviewed for this report, ten had private kitchens, three had family kitchens in shared-living family homes, and two included no kitchens.

Some facilities have a "Pullman-type" Kitchen in each living unit. This is a combination unit consisting of two burners and a sink over a refrigerator, and a detached cupboard above the unit. This is installed in a closet-sized area. Aside from the small size, it is difficult for many elderly to bend down to retrieve items from the refrigerator, and this often requires getting down on one's knees. Also, there is a safety issue involved as there is no drainboard and the stove burners are three or four inches away from the sink; and residents (who may be frail) often use stools to reach items in the overhead cupboard.

A related issue is seen regarding the size of living units. One- and two-bedroom units are preferred over efficiency apartments. Most projects have waiting lists for larger units, but studios remain vacant even in areas where people need housing. Contrary to what may seem logical, lower income residents place greater importance upon larger units than higher income residents. One manager explained that low income persons used their homes as the center of their social lives since they could not afford activities outside the home. Reducing the size of their living space and eliminating kitchens reduced their "living" space.

If required to choose, congregate housing residents preferred a private kitchen over a private bathroom, and preferred a private toilet over a private shower or tub (Urban Systems, 1978; Welch, *et al*, 1984). Some residents prefer a shower because it is easier to get in and out, so a tub with a shower is not the answer. Other residents prefer a bathtub for soaking, or for medical or other reasons.

Advantages and Disadvantages

- The congregate housing/services concept provides an "accommodating" rather than a "constant" living environment: it flexibly meets the changing needs of residents.
- The congregate housing/services concept is a viable alternative to bridge the gap between the extremes of complete self-sufficiency and the custodial care of an institution.
- There is inherent financial incentive to provide minimum therapeutic intervention and to maximize preventive care, which promotes resident independence and counters resident assumption of the "patient mode" common in institutional facilities.
- Congregate programs enhance the quality of life for older adults.
- Segregating congregate program residents by functional ability may result in the establishment of additional levels of institutionalized care.
- The character of living environments are often defined by public funding policies; these policies can promote segregation by abilities, or can create incentives for mainstreaming older adults into integrated environments.
- To maintain market appeal, contain costs, and mirror life in the general community, congregate housing/services projects should maintain a resident population mix of ages and functional abilities.

Estimates indicate that between one and three million older adults would presently benefit from housing with integral services (Sherwood and Bernstein, 1985; Urban Systems, 1976; Donahue, 1981). For the great proportion of older persons who are female, single/widowed, lonely, over-housed, and have low income, a congregate living environment provides the emotional and financial security inherent in 24-hour emergency response and the available and affordable services and shelter.

Research has shown that loss of a confidant is a major factor in depression among the elderly and simply increasing social activity in place of this loss does not counter depression (Lowenthal & Haven, 1968). However, group activities and living in close proximity to others who are similar in age and life status create a fertile environment for developing close friendships and replacing lost confidants.

Lawton describes congregate housing as an "accommodating" environment (Sherman, 1985). It can change to accommodate the evolving needs of its residents, in contrast to a "constant" environment which is not flexible, but requires residents to move when their needs change beyond the capability of the environment to meet those needs.

When their environment is a viable one, older adults prefer to age where they are (Ward, 1984; Sherman, 1985; Shanas, 1968; Lawton, 1978); and involuntary relocation has negative affects on older adults' physical and mental conditions (Hiatt, 1977; Borup, 1979; Lieberman and Tobin, 1983). The accommodating environment of a congregate housing/services facility allows older persons to age-in-place, with coordinated health, social, and recreational services available and easily accessible. In contrast, because of the licensing and regulatory requirements, institutional facilities do not include as much variability in design and management as does congregate housing/services projects; and the institution's staff, not the residents, control the types and timing of most social events and basic activities of daily living (Heumann, *et al*, 1985).

The congregate housing/services concept can meet a spectrum of demands and is

compatible with a variety of lifestyles. Its services are a convenience for active, mobile older adults and are support provisions for those with lesser physical capabilities. Contrary to institutional living, residents are not obligated to use the services, but, instead, have choices as to which services they will use and at what level of intensity they will use those chosen services. The congregate concept provides a living alternative which fulfills Lawton's Adaptation Model of environment which purports that an individual at a given level of competence will be optimally adjusted at a given level of environmental demand (Sherman, 1985).

Policy makers express concern that easily accessible services will result in increased use of those services. There appears to be no relationship between availability of services and increased usage (Zimbalist, 1980; Tell and Wallack, 1984; Winklevoss and Powell, 1984). Malozemoff (1978) found that utilization of medical services among the majority of residents surveyed was extremely low, and a considerable number continued to see and pay for their own doctors in the community even if the congregate facility's physician services were included in the monthly charge. There is a financial incentive for managers of a congregate program to keep health service usage to a minimum and to utilize preventive services as a cost containment measure and to enhance the program's marketability. Publicly subsidized programs use professional assessment committees (PACs) to individually assess clients for needed services. The incentive for preventive services is applauded by gerontologists whose research has shown that minimum service intervention promotes a person's sense of independence and counters the assumption of the dependent "patient mode" that occurs in medical model environments such as acute care hospitals and nursing homes which routinely provide intensive service.

Congregate housing/services programs are emerging as the viable alternative to fill the growing gap in services resulting from the policy changes in reimbursement systems for acute care and skilled nursing (Diagnostically Related Groupings Prospective Payment System and the Resource Utilization Groupings System). Congregate programs provide a wide range of assistance to allow for the longer and more intensive at-home recuperation time following illnesses and provides an affordable assisted environment for those elderly who no longer meet the "heavy-care" eligibility criteria for skilled nursing.

Lack of access to community services and social events is a cause of reduced involvement and activity among older adults living in the general community (Urban Systems, 1978). Accessing these community functions and services requires planning, transportation, and a certain level of mobility. The availability of on-site or brokered services in a congregate housing/services project alleviates the problem of access. As congregate residents' activity in the general community declined because of age and health status, activity within the congregate community was prolonged beyond the point when it would naturally have begun to decline (Urban Systems, 1978). Malozemoff (1978) concurs, finding off-site participation a function of age, health status, and accessibility, while finding health status the only variable to have a consistent effect on reducing the level of activity within a congregate program. Participation in programs and activities increased in number and frequency among congregate residents of all age and income groups compared to their previous participation while in the general community. Residents' new relationships within the facility did not replace previous relationships, and residents' interactions with family members remained the same or increased.

Most congregate projects will claim a reduction in institutional placement, reduced

use of acute facilities, and an increase in quality of life; but surveys often do not make reliable comparisons, so conclusions are difficult to draw. Also, results of surveys are not consistent enough to be generalizable from project to project because the unique character of each project affects outcome. Sherwood (1985) found that the Department of Housing and Urban Development's Congregate Housing and Services Program intervention, after 30 months, had no impact on death rates comparing program participants and matched controls. However, the HUD program population, while vulnerable, was not a severely impaired one. In comparison, Sherwood's (1981) evaluation of the Highland Heights medical congregate project (where participants required intensive service) showed that during the first four years program participants were significantly less likely to die than control members (who were applicants to Highland Heights and, thus, similarly impaired).

In a study of 78 older adults moving into a congregate facility and 122 moving into a traditional housing facility (no services) (Sproat, 1976), tenants in the traditional facility increased or maintained their involvement with the general community and in their use of leisure activities, while congregate residents showed no increase in general community involvement, but did show improvement in morale, housing satisfaction, and loner status.

Residents of an Intermediate Housing project (non-medical services) experienced overall satisfaction with living arrangements compared to their previous location and had increased enjoyment of life and social contacts compared to controls who had applied to the project but did not enter (Brody, 1975). Sherwood, *et al*, (1985), in comparison studies of nursing home/geriatric day hospital, nursing home/senior center, and senior center/geriatric day hospital, found no overwhelming differential quality of life effects emerge after nine months of placement (quality of life: satisfaction with life, personal adjustment, psychological dependency, reality orientation, anxiety, and hostility). However, the researchers found that a more qualitative analysis suggested that clients served in less restrictive environments appeared to do better with independent living skills.

Lawton (1976; 1980), in comparing the effects of congregate housing and traditional housing on elderly tenants, found congregate housing tenants showed improvements in morale, housing satisfaction, socialization opportunity, and loner status, but decreases in involvement with the external community relative to traditional housing tenants.

A potential disadvantage of congregate programming is the segregation of older adults by age and functional level. Construction of facilities expressly for residents who meet functional impairment criteria may be isolating a categorized group of elderly into another level of institutionalized care, obviating its residential character. For example, Washington State's program, which subsidizes services to residents in homes serving 3 - 400 persons, refers to its facilities as having an average of 20 "beds." Similarly, increasing the percentage of residents in a senior housing project who receive service assistance may result in changing the character of the building from residential to institutional. Five states surveyed, who provide congregate services in existing senior housing, limit the program to between 20 and 30 per cent of the building to avoid compromising the integrated environment.

Separating populations by age, and then by abilities, fosters stereotyping and misconceptions about aging and disease. However, co-mingling older people of varying abilities has few advocates, even among the elderly themselves. Some funding sources, particularly SSI and medicaid, exert pressure to form policies and programs which create rigorously differentiated levels

of care by giving financial incentive for segregation. In the 1980's the trend toward subsidies for in-home care and block grants to support congregate programs provides an opportunity to develop programs which will respond flexibly to aging as a variable process rather than a fixed category of abilities (Hiatt, 1977). Funding policies can promote integrated programming and provide incentives for innovative mainstreaming of older adults.

A congregate facility will mirror the characteristics of the community in which it is located. For example, the population of one urban congregate housing/services project in Connecticut is a mix of low-income Black, White, and Hispanic. The management was having great difficulty in getting these three groups to interact. However, their difficulties reflected the distrust among these three population groups in the low socio-economic area from which this facility drew its residents. There was very little congregate resident interaction with the surrounding community, and residents were afraid to walk outside. Gardening could not be done because "if we planted tomatoes, someone would steal them." This facility could not count on community volunteers as a means of cost reduction or increased staff/resident ratio. In contrast, another Connecticut site was located in a rehabilitated elementary school in a middle class suburb. The school had been a focal point for the community's children and subsequently became accepted as an integral part of the community for its older adults. There was continuous interaction between the facility and community individuals and organizations. For example, boy scouts assisted residents in gardening, and Little League games continued on the facility's grounds with congregate facility residents selling hot dogs at the games.

A high-rise may appear as an old age institution in a suburb or rural area, but be a welcome, new housing alternative and a status symbol in an urban area. One "Yankee" town viewed "shared living" as an admission of failure. Mistrust, tension, or competition between service organizations in a community may translate into disputes between those groups and/or the managers about who is responsible for providing services, resulting in non-cooperation or even gaps in service. Costs and methods of delivery are affected differently in service rich and service poor areas.

A common argument against the congregate housing/services concept is that projects take longer to achieve 100 per cent occupancy than do conventional housing projects. Often managers cannot use a traditional first come, first served basis for choosing from the waiting list, but must select residents appropriate to congregate living (Mass. Final Report, 1984). Also, government sponsored programs may dictate who can fill a vacated apartment; for example, requiring that studios be rented only to individuals and one-bedroom apartments be rented only to couples. In order to keep market appeal and maintain a resident group that stays within feasible service (and cost) boundaries, a population mix of ages and functional levels must be maintained in order that a continuing proportion of residents die and be replaced by younger, less impaired occupants instead of an entire group aging together and eventually placing a cost and service strain on the facility.

Tenants must be selected in such a way that the number of residents dying over a five-year period equals the number of residents in the youngest age group, and replacements are always made to the youngest group (Thompson and Donahue, 1980). Suggested formulas include: (1) Ten per cent aged 62-68, 80 per cent 69-74, ten per cent 75+; or (2) 75 per cent residents who may need only the meal service or who suffer only social or psychological impairment, but can otherwise care for all other activities of daily living; 20 per cent residents who will need both the food program and housekeeping and some help witih ADLs;

and five per cent residents who are frail and require all of the services all of the time (International Center for Gerontology, 1978).

Use of such formulas increases in significance as the effects of the aging-in phenomenon are seen across the country. This phenomenon has had an impact upon the administrators managing senior housing, the service program providers, and the residents themselves. In senior housing buildings with no service programs, housing managers whose duties were traditionally confined to "housing-related" concerns are finding that 50 per cent or more of their time is spent in responding to the personal needs of their residents; and the two biggest concerns of these managers are "residents' health" and "the ability of residents to care for themselves" (Housing the Elderly, 1987; Wisconsin Survey Research Lab., 1986). In buildings where services are available, program providers are finding that increasing longevity and availability of intensive in-home care from private vendors are combining to result in increasing numbers of residents who are no longer appropriate for private apartment living, but who exercise their first choice to age-in-place and whose families resist relocation of their older members because of the impoverishing costs of institutional care. As the number of residents in senior housing who require assistance increases, fear among unimpaired residents grows that the character of their living environment will change to resemble a nursing home.

This situation has highlighted a looming major policy debate; that is, the issue of discharge: to what extent should intensive services be provided in order to continue to maintain residents in their own apartments; what are appropriate discharge policies; can discharge policies be enforced (and what are the legal implications for housing managers, service providers, and residents); and who should make the relocation decision. Philosophies vary among both housing managers and service providers, with some feeling that the "well-elderly" image of a building should not be compromised, and others feeling that residents should be permitted to remain in their apartments as long as services can maintain them. The attitudes of residents are often a function of the aging process, with younger and unimpaired elderly opposing the presence of impaired residents, wheel chairs, nursing staff, etc., but finding their attitudes softening as they themselves require services.

The average age of residents in traditional senior housing and in congregate housing has increased, as has the average age of those on the waiting lists, who then fill vacancies at older ages. A consequence of this has been a gradual shift in attitude among younger well-elderly persons in the general community to delay moving into these buildings until they are older (late 70's) and feel an impending need for assistance. A second consequence is a sharp decrease in the amount of time elapsing between residents' entry into senior housing facilities and the need for supportive assistance. Managers of new facilities are finding a significant number of residents requiring supportive services within 18 months to three years following initial rent-up of the building. A third consequence is adamance on the part of some housing managers that residents leave as soon as impairment compromises their independence in order to maintain the marketability of the housing facility. A fourth consequence is the recognition among developers that the 80+ population represents a growing housing market for the development of "assisted living" facilities, with the marketing of these facilities to those older adults who require assistance upon entry.

These trends may result in the increased segregation of "well elderly" and "impaired elderly" and result in the addition of another constant-environment/level-of-care rather than the promotion of in-home-service/residential-environments for mixed case populations which reduce need for relocation and which imitate life in the general community.

Conclusion

Appropriate housing and service alternatives are needed to accommodate the varied needs and preferences of the growing number of older persons. The congregate housing/services concept is one alternative which can flexibly meet the needs of older adults as they change over time. The availability of appropriate and affordable shelter and supportive services extends the period of time that older persons can maintain an independent life style, and the social aspects of a congregate program act as a preventive agent to the development of the type of mental depression commonly found among elderly people.

On a case basis, for nursing-home-eligible individuals assessed as requiring "light-care," congregate housing is cost effective relative to nursing home care. As New York's Resource Utilization Groupings reimbursement mechanism for skilled nursing facilities is implemented in states across the country, more stringent entry criteria for nursing home admittance will result in a more efficient use of Medicaid dollars as beds are filled with only those patients requiring "heavy-care," but will leave a service gap for those requiring a sheltered environment but requiring less intensive care.

Thus, while some argue for the development of congregate housing based on the cost differential between congregate housing and skilled nursing facilities, congregate housing/services programs should not be considered a substitute for nursing homes. As the number of frail elderly (85+) increases, the need for nursing home care for individuals requiring "heavy-care" will continue to increase, and congregate housing/services should be considered an additional option of community-based services in the continuum of appropriate support necessary during the later years. Because of its flexibility in providing only that level of services required on an individual basis, congregate housing/services programs successfully bridge the wide range of needs between the extremes of total self-sufficiency and the custodial care of an institution.

It is tempting to try to identify one best congregate concept model and a most cost effective method of service delivery within that model. However, as is evidenced by the diversity of program variations in place across the nation, there is no one model or delivery method which can be deemed the best path to follow in providing community-based services. The inherent complexity of variables within these programs make cost comparisons among them inconclusive. However, this very difficulty which prevents arriving at a definitive model may be serendipitous. Of all the age groups, the elderly are the most diverse in terms of needs and preferences. Successful development of appropriate living alternatives for this group depends upon providing maximum choice along the continuum between housing with no services and shelter with the highest level of services. The major advantage of the congregate housing/services concept is its capability of being implemented in many variations to take advantage of the unique conditions and characteristics of each locale and to utilize the creativity of sponsors and staff to cost effectively adapt the program to individual residents rather than mold participants to fit a static model.

The current lack of a sufficient number of appropriate housing units for older adults in New York has resulted in extremely low vacancy rates in senior housing, long waiting lists, and an increase in average resident age as both residents and waiting-list applicants age in place. As the movement to develop more senior housing grows in public and private sectors in response to identified need and market demand, policy makers must

guide this development to avoid what may be the easier route for developers: creating housing models which segregate older adults by functional profile and which will result in several levels-of-care rather than promoting integrated, flexibly supportive, residential environments.

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